Supreme Court, U.S.
FILED
MAY 7 1996
OFFICE OF THE CLERK

NO. 951817

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

JANETTE M. WIFE OF/AND CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

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QUESTIONS PRESENTED

I. Whether the Supreme Court of the State of Louisiana and other Louisiana courts erred in refusing to and not following the decisions, guidelines and/or standards used or established by the United States Court of Appeal, Fifth Circuit for determining whether an employer established medical expense plan for employees is a plan covered by the Employee Retirement Income Security Act, 29 U.S.C. §1001 et seq. (ERISA). The decision of the Supreme Court of the State of Louisiana in upholding a decision of the Louisiana Court of Appeal, Fifth Circuit is in direct conflict with decisions of the United States Court of Appeal, Fifth Circuit, on the same issue.

LIST OF PARTIES

In accordance with Supreme Court Rule 14(b), petitioner submits the following list of all parties to the proceeding in the Supreme Court of Louisiana, whose judgment is sought to be reviewed. The parties are, to-wit:

A. List of Petitioners

1. Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana) (erroneously referred to in plaintiff's proceedings as "Blue Cross/ Blue Shield of Louisiana")

B. List of All Other Parties

2. Janette M. Kornman

3. Charlie Kornman

4. Richard Jay Kornman

5. Estate of Charlie Kornman

6. Janette M. Kornman, Executrix of the Estate of Charlie Kornman

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NO.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

The petitioner, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana), respectfully prays that a writ of certiorari issue to review the Judgment of the Supreme Court of the State of Louisiana entered February 16, 1996.

CITATIONS OF THE OFFICIAL OPINIONS ENTERED IN THIS CASE BY COURTS

1. The opinion of the Supreme Court of Louisiana denying an Application for Writ of Certiorari and/or Review to review the opinion of the Louisiana Court of Appeal, Fifth Circuit, is reported at 667 So.2d 1054 (Appendix A)

2. The opinion of the Louisiana Court of Appeal, Fifth Circuit, is reported at 662 So.2d 498 (Appendix B)

JURISDICTION

The Judgment of the Supreme Court of the State of Louisiana was entered on February 16, 1996. No petition or application for rehearing was filed since pursuant to its rules, Rule IX, Section 6 (Appendix J) the Supreme Court of the State

of Louisiana will not consider a rehearing when it denies an application for a writ of certiorari and/or review. The jurisdiction of this Honorable Court is invoked under 28 U.S.C. §1257(a)

STATUTORY PROVISIONS INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. (ERISA), more specifically Section 1002(1) of ERISA, 29 U.S.C. §1002(1), which provides in relevant part:

> For the purposes of this subchapter:
>
> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

STATEMENT OF THE CASE

This suit was originally brought in the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana, and was given the number 364-688 on the docket of

that court. The original plaintiffs in the suit were Charlie Kornman and his wife, Janette Kornman. They filed suit on their behalf and on behalf of their alleged dependent son, Richard Kornman. At the time suit was filed Richard Kornman was 28 years old. Richard Kornman was later added as a party-plaintiff, and after Charlie Kornman's death, the Succession of (estate of) Charlie Kornman represented by Janette Kornman, Executrix of the Estate of Charlie Kornman, was substituted as a party-plaintiff. All of the plaintiffs are hereinafter referred to collectively as "Kornmans".

Charlie Kornman was one of twenty (20) or more employees of Coast Quality Construction Corporation ("Coast"). Coast created, maintained and provided to its twenty (20) or more employees a medical expense plan ("Coast MEP") and made application to Louisiana Health Service & Indemnity Company (Blue Cross/Blue Shield of Louisiana) (hereinafter "Blue Cross") to insure the plan. The purpose of the plan was to provide health benefits for the employees and provide for payment of medical expenses incurred by the employees of Coast. The plan provided that, when an employee made a claim for medical benefits under the plan, a determination would be made whether or not the plan provided coverage and payment of the medical expenses set forth in the claim. The plan further provided that, if an employee disputed the decision as to coverage and/or payment of a claim, then the employee might appeal to Blue Cross' ERISA review department. (See Appendix I) The undisputed facts in this case are that Coast arranged the plan, determined what medical benefits the plan would provide, determined that it would be a plan insured by Blue Cross and what would be insured by Blue Cross. Coast was billed directly for all premiums and fees due under the agreement with Blue Cross, and Coast paid all premiums and fees directly to Blue Cross. In addition, Coast paid 75% of the premiums owed by each eligible

employee. The employees paid the remaining 25% of their premiums through payroll deductions, which were administered by Coast. As mentioned, these facts are not in dispute.

No insurance contract or policy was made or entered into between Blue Cross and Charlie, Janette or Richard Kornman ("Kornmans"). The insurance in this matter was provided by Blue Cross to Coast and its medical expense plan ("Coast MEP") and not to the Kornmans. Coast provided medical benefits to Charlie Kornman and his wife, Janette Kornman, only by virtue of the fact that Charlie Kornman was an employee of Coast who enrolled in the medical expense plan established by Coast. Coast, as noted above, paid 75% of the premiums due Blue Cross and controlled and administered all funds deducted from employees' paychecks to pay the remaining 25% of premiums due. Coast further assumed responsibility for submitting the premium payments to Blue Cross. Charlie Kornman was only one of twenty (20) or more of Coast employees who became participants and beneficiaries of the Coast Medical Expense Plan ("Coast MEP"). These facts are also undisputed.

In their pleadings, Charlie and Janette Kornman allege that pursuant to Louisiana law Blue Cross is liable for medical expenses incurred by Richard Kornman as a result of his eleven month stay (from May, 1987 to April, 1988) at Coliseum Medical Center ("Coliseum") and his treatment there for alleged drug use and abuse. It is undisputed that Blue Cross had no previous knowledge of Richard Kornman's drug problem until it received the claim, which is the subject matter of this case, for Richard Kornman's confinement at Coliseum.

Richard Kornman was born on December 2, 1959. At the time of his treatment, at Coliseum Medical Center, Richard Kornman was 27 years old. The Kornmans allege that Richard

Kornman was a dependent of Charlie and Janette Kornman during his confinement.

The position of Blue Cross relative to the medical expense plan established by Coast for its employees is that it was a medical benefit plan under the Employee Retirement Income Security Act (ERISA) because it involved a program established or maintained by an employer for the purpose of providing health benefits for the employee through the purchase of insurance or otherwise. 29 U.S.C. §1002(1) Blue Cross determined that the Coast MEP insured by Blue Cross did not provide coverage for the claims made by the Kornmans for Richard Kornman's treatment at Coliseum.

Thereafter, the Kornmans brought suit in the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana. In said suit, the Kornmans requested penalties and attorney fees which they alleged they were entitled to under Louisiana law. Blue Cross removed the Kornmans' suit to the United States District Court for the Eastern District of Louisiana on the ground that it was a matter governed by the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §1001, et seq.; 29 U.S.C. §1002(1); 29 U.S.C. §1132(a)(1)(B), and that plaintiffs' claims were preempted by ERISA. Specifically and as mentioned above, it is Blue Cross' position that the medical expense plan at issue in this matter provided by Coast to its employees and insured by Blue Cross is "an employee welfare benefit plan" as defined by ERISA, 29 U.S.C. §1002(1), and ERISA, 29 U.S.C. §1144 preempts the Louisiana law under which the Kornmans' make their claim, including Louisiana the law providing for penalties and attorneys' fees.

The Kornmans thereafter filed a Motion to Remand contending that the Coast MEP was not an ERISA plan. The

Judge in the U.S. District Court when he considered Kornmans' Motion to Remand did not hold any hearings, take any evidence or provide counsel for Blue Cross an opportunity to argue opposition to the Motion to Remand. He simply decided the matter on briefs and ordered the Kornmans' suit remanded to the 24th Judicial District Court, Parish of Jefferson, State of Louisiana. (Appendix C) The Judge in the U.S. District Court did not have before him the undisputed facts that Coast arranged the plan, determined what medical benefits the plan would provide, and determined that the plan would be insured by Blue Cross and what would be insured by Blue Cross. Coast was billed directly for all premiums and fees due under the agreement with Blue Cross, and Coast paid all premiums and fees directly to Blue Cross. Further, Coast paid 75% of the premiums owed by the 20 or more eligible employees who participated in the plan, and the employees paid the remaining 25% of their premium through payroll deductions which were administered by Coast. The Judge in the U.S. District Court did not have before him the above undisputed involvement of Coast with the medical expense plan for its employees.

The Judge in the United States District Court made his decision to remand this case to the state court relying on the case of Taggart Corp. v. Life & Health Benefits Administration, Inc., 617 F.2d 1208 (5th Cir. 1980) cert. denied 450 U.S. 1030 (1981) which was the only United States Court of Appeal, Fifth Circuit, case available as precedent for the judge in the U.S. District Court to consider. However, since that time, the United States Court of Appeal has promulgated several other cases which limit Taggart, supra. to its particular facts and which later cases further define, in the United States Court of Appeal, Fifth Circuit's opinion, what constitutes an ERISA plan. See Memorial Hospital Sys. v. Northbrook Life Insurance Co., 904 F.2d 236, 242-43 (5th Cir. 1990); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016-17, n. 2 (5th Circ. 1993); Kidder v. H & B Marine,

Inc., 932 F.2d 347 (5th Cir. 1991), Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991). The United States Court of Appeals, Fifth Circuit, has determined in these later cases what standards and/or guidelines it uses to determine if an employer established medical plan for its employees is an ERISA plan. The Fifth Circuit uses as a guideline the employer's involvement with and relationship to the plan.

Following the remand of the Kornmans' suit to the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana, the trial court, Blue Cross filed exceptions and a memorandum in support of the exceptions (Appendix H) in order to preserve its argument and the federal question that the Coast MEP was an ERISA plan. Blue Cross further argued, *inter alia*, that since the Coast MEP was an ERISA plan, ERISA governed this matter, and that the Kornmans had failed to join a necessary party, i.e. the Coast MEP, the Kornmans' suit was premature and the Kornmans' claims were preempted by ERISA. (Appendix H) The Twenty-Fourth Judicial District Court, the trial court, without written reasons rendered a judgment denying the Exceptions. (Appendix D)

Following trial of this matter, during which, petitioner, Blue Cross continued its argument that the Coast MEP was an ERISA plan, the Twenty-Fourth Judicial District Court, Parish of Jefferson, State of Louisiana, held for the Kornmans and awarded them judgment. From that judgment, Blue Cross took an appeal to the Louisiana Court of Appeal, Fifth Circuit. In order to continue to preserve its argument and the federal question that the Coast MEP was an ERISA plan, petitioner, Blue Cross, took the appeal to the Louisiana Court of Appeal, Fifth Circuit, for the reasons set forth in its brief (Appendix F), including but not limited to, that the Twenty-Fourth Judicial District Court, Parish of Jefferson, State of Louisiana, erred in not holding that the medical expense plan established by Coast

for its employees ("Coast MEP") was an ERISA plan and therefore the claims of the Kornmans were preempted, the Coast MEP was an indispensable party, the Kornmans' suit was premature, and the Kornmans were not entitled to penalties under ERISA.

The Court of Appeal, Fifth Circuit, affirmed the Judgment of the 24th Judicial District Court, the trial court, holding that it would not follow the decisions made and guidelines and standards used and established by the United States Court of Appeal, Fifth Circuit, in Memorial Hospital Sys., supra, Kidder, supra, and Hansen v. Continental Insurance Company, supra. Consequently, the Court held that the Coast MEP was not an employee medical expense plan, and ERISA plan, as defined by the Employee Retirement Income Security Act (ERISA). The Louisiana Court of Appeal, Fifth Circuit, further said in its opinion that the factual distinction made by the United States Court of Appeal, Fifth Circuit, of the Taggart case, supra, was "inappropriate". In its decision, the Louisiana Court of Appeals, Fifth Circuit, further said that since the Coast MEP was not an ERISA plan, it did not have to consider the Blue Cross arguments relative to preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties. (Appendix B)

Thereafter, petitioner, Blue Cross, made a timely application for rehearing to the Louisiana Court of Appeal, Fifth Circuit and continued to argue that the Coast MEP was an ERISA plan. (Appendix G) However, the Louisiana Court of Appeal, Fifth Circuit, refused to grant a rehearing to petitioner, Blue Cross (Appendix E).

Petitioner, Blue Cross, thereafter made application to the Supreme Court of the State of Louisiana, the state court of last resort, for a writ of certiorari and/or review of the judgment of the

Louisiana Court of Appeal, Fifth Circuit. In said application for writ of certiorari and/or review (Appendix K), petitioner, Blue Cross, continued to argue, among other things, that the Coast MEP for its employees was an ERISA plan and that the Supreme Court of the State of Louisiana should grant the writ of certiorari and/or review and reverse the Louisiana Court of Appeal, Fifth Circuit and find that the Coast MEP was an ERISA plan and consider the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties or remand the case to the Louisiana Court of Appeal, Fifth Circuit, to decide these issues. The Supreme Court of the State of Louisiana, however, denied the application for writ of certiorari and/or review of Blue Cross on February 16, 1996, (Appendix A). The Supreme Court of the State of Louisiana pursuant to its rules will not consider an application for rehearing when the Court denies an application for a writ of certiorari and/or review. Louisiana Supreme Court Rules, Rule IX, Section 6 which states:

> **Section 6.** An application for rehearing will not be considered when the court has merely granted or denied an application for a writ of certiorari or a remedial or other supervisory writ, or when the judgment of this court is merely overruling a motion to dismiss an appeal or a motion to recall or rescind a rule nisi . . ."

The Supreme Court of the State of Louisiana is the court of last resort in the State of Louisiana and therefore Blue Cross files this petition and requests this Honorable Court to grant a writ of certiorari to review an important federal question decided by a Louisiana state court of last resort that conflicts with decisions of a United States Court of Appeal and further for the reason that a Louisiana court has decided an important question of federal law that has not been, but should be settled by this Honorable Court.

ARGUMENT AND REASONS FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI

There is now a conflict between a decision in the Louisiana courts and decisions of a United States Court of Appeal. This conflict arises as a result of the decision and judgment of the Louisiana Court of Appeal, Fifth Circuit, (Appendix B) and the denial by the Supreme Court of the State of Louisiana, the state court of last resort, of a writ of certiorari and/or review to review that decision (Appendix A).

In its decision in this case (Appendix B) that causes this conflict, the Louisiana Court of Appeal, Fifth Circuit, states:

> On remand, appellant reurged its argument to the state trial court that ERISA applied. Adopting the reasons set forth in the Eastern District Court's order, the trial court likewise found ERISA did not apply.
>
> On appeal, despite the findings of both the Eastern District Court and the state trial court, Blue Cross continues to assert ERISA governs this case.[4] Blue Cross bases its argument on recent federal Fifth Circuit cases[5], de-

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[4] If ERISA applies, plaintiffs would be prevented by federal preemption from recovering penalties allowed under state law for an insurer's arbitrary and capricious failure to pay a claim. See Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990); cert. denied, 499 U.S.. 938, 111 S.Ct. 1391, 113 L.Ed.2d 447 (1991).

[5] These cases include Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991); Kidder v. H & B Marine Inc., 932 F.2d 347 (5th Cir. 1991); and Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990).

cided after the 1988 Eastern District Court's order of remand, which severely restrict Taggart Corp. v. Life & Health Benefits Admin., supra, the sole case relied on by both the Eastern District Court and the trial court in determining Coast's MEP was not an ERISA plan. Blue Cross asserts Coast's MEP would qualify as an ERISA plan under the guidelines established by these new federal cases. However, plaintiffs argue the new federal cases cannot be retroactively applied because to do so would divest them of a vested right, namely the right to penalties and attorney's fees, given them as a matter of state law.[6]

In matters involving federal law, we, as a state court, are only "bound" by decisions of the United States Supreme Court. Gaspard v. Transworld Drilling Co., 468 So.2d 692 (La. App. 3 Cir. 1985), writ denied, 474 So.2d 1304 (La. 1985), cert. denied, 475 U.S. 1067, 106 S.Ct. 1382, 89 L.Ed.2d 607 (1986). Federal appellate court decisions, such as decisions rendered by the Federal Fifth Circuit, are merely persuasive. State v. White, 321 So.2d 491 (La. 1975). As a state court, we have authority to render decisions based on our own interpretation of federal law provided federal courts do not have exclusive jurisdiction over the matter. Asarco Inc. v. Kadish, 490 U.S. 605, 109 S.Ct. 2037, 104 L.Ed.2d 696 (1989). Thus, since we share concurrent jurisdiction

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6 We note the only cause of action affected by the application of ERISA is for the recovery of penalties because attorney's fees may be recovered under ERISA. See 29 USC §1132(g)(1) which provides, ". . . the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."

with federal courts over ERISA matters[7], we are not technically bound by the newer federal cases relied upon by appellant.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 for the purpose of protecting workers participating in employee benefit plans from misappropriation and misuse of funds paid into the plan and other abuses by regulating the administration of the plans. 29 U.S.C. §1001(b).[8] ERISA applies to any "employee benefit plan" established or maintained by any employer or employee organization engaged in commerce, or in any industry or activity affecting commerce. 29 U.S.C. §1003(a). While ERISA regulates two types of benefit programs, pension plans and welfare plans, our concern is with the welfare plan. An "employee welfare benefit plan" is defined as

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training pro-

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7 See 29 USC §1332(e)(1).

8 See also, Comments, *Small Employers and Group Health Insurance: Should ERISA Apply*?, 52 La.L.Rev. 971 (1992).

grams, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) or this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. §1002(1)

There have been many cases which have attempted to set forth guidelines to determine whether a particular insurance arrangement constitutes an "employee welfare benefit plan." In 1980, the federal Fifth Circuit held that "bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits" are not governed by ERISA. Taggart Corp. v. Life & Health Benefits Admin., supra. In deciding Taggart the Court was careful to consider ERISA's purpose and legislative history. The Court determined ERISA's purpose would not be served in the Taggart case because the plan at issue did not have any assets which ERISA's safeguards were intended to protect.

However, since 1980, the federal Fifth Circuit has severely limited the Taggart holding by factually distinguishing Taggart on the fact it involved a corporation with only one employee who was essentially purchasing insurance for himself and his family, as opposed to purchasing insurance for a group of employees, through a multiple employer trust. We find this factual distinction as the reason for the more recent federal Fifth Circuit cases not to follow Taggart inappropriate. The factual distinction disregards the purpose and legislative history of ERISA which was so carefully considered by the Court in Taggart.

> The later federal cases, while refusing to overrule the "bare purchase" analysis of Taggart, hold that the purchase of a group policy along with the payment of premiums offers "substantial evidence" that a plan has been established. But, the Court admits the mere payment of premiums is insufficient to create an ERISA plan. See Kidder v. H&B Marine, Inc., 932 F.2d 347 (5th Cir. 1991), and Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). In focusing on the employer-employee-plan relationship, the Fifth Circuit Court has apparently abandoned its focus on whether the "plan" is a trust that has assets which are to be protected by the ERISA safeguards.
>
> Because we believe the later federal Fifth Circuit cases are not in accord with Congressional intent, we decline to follow them and instead adhere to the "bare purchase" rationale of Taggart without making what appears to be inconsequential factual distinctions. In Taggart, the employer purchased a group insurance policy through a multiple employers trust (MEP). The employer paid its premiums to the MET which in turn forwarded the premiums to an insurer. The employer did not participate in the day-to-day operations or administration of the MET.
>
> (emphasis ours)

This Honorable Court should grant this petition for writ of certiorari and now resolve this conflict between the Louisiana courts and the United States Court of Appeal, Fifth Circuit, as to whether the guidelines and/or standards as set forth by the United States Court of Appeal, Fifth Circuit, in the cases of Memorial Hospital Sys., 904 F.2d 236, Rodriguez, 980 F.2d 1014, Kidder,

932 F.2d 347 and Hansen, 940 F.2d 971, are appropriate guidelines and standards to follow in determining whether a medical expense plan provided by an employer to its employees is an ERISA plan to be governed by the Employee Retirement Income Security Act 29 U.S.C. §1001, et seq. (ERISA) The Louisiana court in its decision says it would be bound by the decision of this Honorable Court, the United States Supreme Court. The Louisiana court says it is not bound by decisions of the United States Court of Appeal and will not follow those decision on this important federal question. The guidelines and/or standards to follow in making a determination as to what medical expense plans are ERISA plans is an important federal question of law that has not been, but should be, settled by this Honorable Court.

This Honorable Court should also resolve the conflict as to whether the factual distinctions made by the United States Court of Appeal, Fifth Circuit, in the Memorial Hospital Sys. case, supra and later cases are appropriate to limit the Taggart case, supra to its facts -- or are these factual distinctions "inappropriate" as decided by the Louisiana court.

The undisputed facts in this case show without any doubt that the Coast MEP for its employees met all of the guidelines and standards set out by the United States Court of Appeal, Fifth Circuit, in Hansen, 940 F.2d 971 (5th Cir. 1991), Memorial Hospital Sys., 904 F.2d 236 (5th Cir. 1990); and Rodriguez, 980 F.2d 1014 (5th Cir. 1993). The Coast MEP was not excluded from being covered by ERISA by Department of Labor Regulations 29 C.F.R. 2510.3(j)(1) since Coast, the employer, made significant contributions to the health plan. Coast paid 75% of the employees' premiums.

The focus guidelines used by the United States Court of Appeal, Fifth Circuit, in determining whether a medical expense plan is an ERISA plan is the employer's involvement in the plan.

See, Memorial Hosp. Sys., supra, at pages 242-43; Rodriguez, supra, at pages 1016-17, n.2.

In Rodriguez, the employees contributed, through payroll deductions, a portion of the insurance premiums; the employer paid the balance. The Fifth Circuit specifically held in Rodriguez that such an arrangement and involvement by the employer established an ERISA plan. Rodriguez, 980 F.2d at 1017, n.2. Likewise, a similar arrangement by the employer was found sufficient in the Memorial Hospital case to establish an ERISA plan. Memorial Hospital, 904 F.2d at 242-43. The facts are undisputed in this case as to the employer's, Coast Quality Construction Co., involvement in the medical expense plan it provided for its employees, one of which was Charlie Kornman. Coast arranged for the plan, chose the coverage the plan would provide to its employees, chose to insure the plan, selected Blue Cross to insure the plan. Further, Coast paid a percentage of each employee's premium and deducted the remaining percentage from each employee's paycheck through payroll deductions. Additionally, Coast controlled and administered all funds deducted from employee's paychecks, assumed responsibility for any balance due Blue Cross for premiums. Certainly Coast, the employer, established and maintained the plan.

In addition, the plan further provided that if an employee disputed a decision as to coverage or payment of a claim, then the employee might appeal to the ERISA Review Department at Blue Cross (Appendix I). All of these facts are undisputed and brought out at the trial and contained in the trial record. Transcript at pp. 987-989 and p. 1730.

The Taggart case, supra, would not be applicable to this case because:

(1) Unlike the Taggart case where there was only one employee, Charlie Kornman was one of twenty (20) or more employees of Coast enrolled in the Coast MEP and not the only employee of Coast enrolled in the medical expense plan as was the case in Taggart.

(2) Unlike the Taggart case, this case does not involve the bare purchase of insurance. Coast, and not a trust entity as in Taggart, was very involved with the medical expense plan as follows:

(a) Coast chose to provide health benefits for its employees and arranged for the plan;

(b) Coast chose the coverage the plan and its insurer would provide to its employees;

(c) Coast paid a percentage of each employee's premium;

(d) Coast deducted the remaining percentage from each employee's paycheck through payroll deductions;

(e) Coast controlled and administered all funds deducted from employee's paychecks;

(f) Coast assumed responsibility for submitting the premium payments to Blue Cross each month; and

(g) Coast assumed responsibility for the balance of the premiums.

The medical expense plan established by Coast for its employees had assets to protect and those assets should be protected by ERISA. Coast and the medical expense plan it established had a fiduciary relationship with its employees who were participants in and members of the medical expense plan, and Coast had a trust of their funds. Coast deducted for the medical expense plan a percentage from each employees pay check through payroll deductions to pay for each employees premium due for participation in the medical expense plan. Coast itself paid the remaining percentage, i.e. 75%, due for each employees premium. Coast controlled and administered for the medical expense plan all funds deducted from employees' pay checks and controlled and administered its own funds to pay premiums. Coast assumed responsibility of the medical expense plan for submitting the premium payments to Blue Cross each month. Coast assumed responsibility for the balance of the premiums due by the medical expense plan. Coast thus established a trust of employee funds and Coast funds to pay premiums due by the medical expense plan. The medical expense plan and Coast had a trust and fiduciary responsibility to Coast employees and the medical expense plan for its employees that ERISA is intended and meant to protect and should protect. Even if there was no "formal" trust or trust fund, one is not required since the Coast MEP was an insured plan. 29 U.S.C.§1103(b)(1), Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236,n.2 (5th Cir. 1990).

It is submitted that this petition for writ of certiorari should be granted to secure uniformity of jurisprudence. Medical expense plans established by employers for their employees with the same set of facts as this case litigated in the United States courts will be determined to be ERISA medical expense plans. However, since the Louisiana Court of Appeal, Fifth Circuit has held that it will not follow the decisions of the United States

Court of Appeal, Fifth Circuit, in the Hansen, Memorial Hospital Sys., Rodriguez and Kidder cases and since the Supreme Court of the State of Louisiana, the court of last resort, has denied an application for writ of certiorari to review the decision of the Louisiana Court of Appeal, these same medical expense plans if litigated in Louisiana courts will be held not to be ERISA medical expense plans. Because of this conflict, there will be unsettling results and confusion. Employers, as well as employees in Louisiana, will not know whether or not they have, or are participants in, an ERISA medical expense plan. There will be no uniformity of jurisprudence and great confusion between the Louisiana courts and the United States courts if this Honorable Court does not resolve this conflict in decisions. The law on ERISA should be the same in state courts and the United States courts.

CONCLUSION

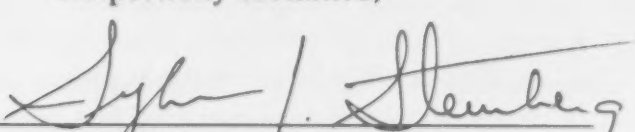
This conflict between the Supreme Court of the State of Louisiana, the Louisiana court of last resort, and the United States Court of Appeal, Fifth Circuit, is an important federal question which has not been, but should be, settled by this Honorable Court. The United States Court of Appeal, Fifth Circuit's, guidelines and/or standards used to determine whether a medical expense plan provided by an employer to its employees is an ERISA plan to be governed by the Employee Retirement Income Security Act, 29 U.S.C. §1001, et seq. is in direct conflict with the Louisiana Court of Appeal, Fifth Circuit's decision that it will not follow the guidelines and/or standards established by the United States Court of Appeal, Fifth Circuit.

This Honorable Court should resolve this conflict and determine if the guidelines and standards established by the United States Court of Appeal, Fifth Circuit, are appropriate guidelines to use to determine if a medical expense plan estab-

lished by an employer for its employees is an ERISA plan. If they are appropriate guidelines, then this Honorable Court may determine that the Coast MEP was an ERISA plan and remand the case for a determination of the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party, and penalties pursuant to ERISA. Or, this Honorable Court may remand the case for determination that the Coast MEP was an ERISA plan under the guidelines established by the United States Court of Appeal, Fifth Circuit, and also the issues of preemption, failure to exhaust administrative remedies, failure to join an indispensable party and penalties.

For these reasons, it is respectfully requested that this Honorable Court grant petitioner's request for writ of certiorari.

Respectfully submitted,



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APPENDIX A

THE SUPREME COURT OF THE STATE OF LOUISIANA

JANETTE M. wife of/and
CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON
RICHARD JAY KORNMAN

VS. NO. 95-C-3025

BLUE CROSS/BLUE SHIELD
OF LOUISIANA

IN RE: Blue Cross Blue Shield of La.; Louisiana Health Serv. & Indem.; - Defendant(s); Applying for Writ of Certiorari and/or Review; to the Court of Appeal, Fifth Circuit, Number 94-CA-0306; Parish of Jefferson 24th Judicial District Court Div. "E" Number 364-688

February 16, 1996

Denied.

WFM

PFC

JCW

HTL

BJJ

JPV

KIMBALL, J. recused.

Supreme Court of Louisiana
February 16, 1996

s/John Tarlton Olivier
Acting Clerk of Court
For the Court

APPENDIX B

JANETTE M. wife of/and CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN	* NO. 94-CA-306 * COURT OF APPEAL * FIFTH CIRCUIT
VERSUS	* STATE OF LOUISIANA
BLUE CROSS/BLUE SHIELD OF LOUISIANA	

APPEAL FROM THE 24TH JUDICIAL DISTRICT COURT
PARISH OF JEFFERSON, STATE OF LOUISIANA,
DIVISION "E", DOCKET NUMBER 364-688
HONORABLE CLARENCE E. MCMANUS, JUDGE

CHARLES GRISBAUM, JR.

JUDGE

SEPTEMBER 26, 1995

(Court composed of Judges Charles Grisbaum, Jr.
Thomas C. Wicker, Jr., and Sol Gothard)

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AFFIRMED

INTRODUCTION

Defendant appeals from the trial court's judgment finding plaintiffs were entitled to benefits for Richard Kornman's 11-month confinement/treatment for drug abuse under the health insurance policy provided by defendant along with penalties and attorney's fees. We affirm.

ISSUES

1. Whether the Coast Quality Construction Company's (Coast) Medical Expense Plan (MEP) is a plan under the Employee Retirement Income Security Act (ERISA);

2. Whether Richard was covered as a dependent under Coast's MEP;

    a. Whether Richard Kornman was capable of self-support;

    b. Whether Charlie Kornman was required to provide proof of Richard's incapacity of dependency when Richard reached age 25; the limiting age;

    c. Whether Blue Cross could have denied Richard's coverage based on information in a health questionnaire;

3. Whether Richard Kornman's treatment at Coliseum was covered by the terms of the policy;

    a. Whether Richard's treatment at the Coliseum fell during the 365-day exclusion period for pre-existing conditions;

    b. Whether Richard was treated for substance abuse or for a mental condition for which there is a policy limit of $5,000;

    c. Whether Richard's treatment at the Coliseum Medical Center was medically necessary.

FACTS

Plaintiffs, Charlie, Janette and Richard Kornman[1], filed suit in state court in June 1988 against Blue Cross/Blue Shield of

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[1] Since filing suit, Charlie Kornman passed away and his estate was substituted as a plaintiff. Additionally, Richard Kornman, was added as a plaintiff after the suit was initially filed.

Louisiana[2] (Blue Cross), seeking medical benefits allegedly owed them under a medical expense plan (MEP) established by their employer, Coast Quality Construction Company (Coast), and insured by defendant. Charlie Kornman was both the owner and an employee of Coast.

Plaintiffs seek recovery for medical expenses incurred by Richard Kornman during an eleven-month stay at the Coliseum Medical Center ("Coliseum"), for treatment for substance abuse. Plaintiffs maintain Richard was covered as a dependent under Charlie Kornman's policy. Alternatively, plaintiffs maintain Richard was covered independently as an employee of Coast. Blue Cross denied coverage under both assertions.

Blue Cross attempted to remove the matter to federal court on the basis ERISA governed but the Eastern District Court found there was no ERISA plan and remanded the matter to the state court. After a sporadic four day trial, the trial court found ERISA did not apply, Richard was covered by Blue Cross as Charlie's dependent and was, accordingly, owed benefits. The trial court awarded plaintiffs $174,423.64 for benefits, $37,940.25 for attorney's fees, $174,423.64 in penalties, $16,351.02 in costs and exert fees, plus interest. Blue Cross appeals this judgment on several grounds.

ISSUE ONE: Is Coast's MEP an ERISA plan?

On July 21, 1988, defendant-appellant filed a petition of removal on the basis plaintiffs' cause of action for the recovery of benefits under Coast's medical expense plan (MEP) was

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[2] Defendant, Louisiana Health Service & Indemnity Company, was erroneously named by plaintiffs as Blue Cross/Blue Shield of Louisiana. However, for purposes of this appeal, we will refer to defendant-appellant as Blue Cross.

governed by ERISA and, thus, a federal question existed for federal court jurisdiction. The United States District Court for the Eastern District of Louisiana remanded the matter finding Coast's MEP did not qualify as an ERISA plan under Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980), cert. denied, 450 U.S. 1030 (1981).[3]

On remand, appellant reurged its argument to the state trial court that ERISA applied. Adopting the reasons set forth in the Eastern District Court's order, the trial court likewise found ERISA did not apply.

On appeal, despite the findings of both the Eastern District Court and the state trial court, Blue Cross continues to assert ERISA governs this case.[4] Blue Cross bases its argument on recent federal Fifth Circuit cases[5], decided after the 1988 Eastern District Court's order of remand, which severely restrict Taggart Corp. v. Life & Health Benefits Admin., supra, the sole case relied on by both the Eastern District Court and the trial

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[3] We note the order of remand is not included in the appellate record. However, appellees attached a copy of the Eastern District Court's order and reasons dated October 21, 1988 to their brief which shows the Court found the plan in question was not an ERISA plan.

[4] If ERISA applies, plaintiffs would be prevented by federal preemption from recovering penalties allowed under state law for an insurer's arbitrary and capricious failure to pay a claim. See Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990); cert. denied, 499 U.S.. 938, 111 S.Ct. 1391, 113 L.Ed.2d 447 (1991).

[5] These cases include Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991); Kidder v. H & B Marine Inc., 932 F.2d 347 (5th Cir. 1991); and Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990).

court in determining Coast's MEP was not an ERISA plan. Blue Cross asserts Coast's MEP would qualify as an ERISA plan under the guidelines established by these new federal cases. However, plaintiffs argue the new federal cases cannot be retroactively applied because to do so would divest them of a vested right, namely the right to penalties and attorney's fees, given them as a matter of state law.[6]

In matters involving federal law, we, as a state court, are only "bound" by decisions of the United States Supreme Court. Gaspard v. Transworld Drilling Co., 468 So.2d 692 (La. App. 3 Cir. 1985), writ denied, 474 So.2d 1304 (La. 1985), cert. denied, 475 U.S. 1067, 106 S.Ct. 1382, 89 L.Ed.2d 607 (1986). Federal appellate court decisions, such as decisions rendered by the Federal Fifth Circuit, are merely persuasive. State v. White, 321 So.2d 491 (La. 1975). As a state court, we have authority to render decisions based on our own interpretation of federal law provided federal courts do not have exclusive jurisdiction over the matter. Asarco Inc. v. Kadish, 490 U.S. 605, 109 S.Ct. 2037, 104 L.Ed.2d 696 (1989). Thus, since we share concurrent jurisdiction with federal courts over ERISA matters[7], we are not technically bound by the newer federal cases relied upon by appellant.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 for the purpose of protecting workers participating in employee benefit plans from misappropriation

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6 We note the only cause of action affected by the application of ERISA is for the recovery of penalties because attorney's fees may be recovered under ERISA. See 29 USC §1132(g)(1) which provides, ". . . the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."

7 See 29 USC §1332(e)(1).

and misuse of funds paid into the plan and other abuses by regulating the administration of the plans. 29 USC §1001(b).[8] ERISA applies to any "employee benefit plan" established or maintained by any employer or employee organization engaged in commerce, or in any industry or activity affecting commerce. 29 USC §1003(a). While ERISA regulates two types of benefit programs, pension plans and welfare plans, our concern is with the welfare plan. An "employee welfare benefit plan" is defined as

> (1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) or this title (other than pensions on retirement or death, and insurance to provide such pensions).
>
> 29 U.S.C. §1002(1)

There have been many cases which have attempted to set forth guidelines to determine whether a particular insurance

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[8] See also, Comments, *Small Employers and Group Health Insurance: Should ERISA Apply*?, 52 La.L.Rev. 971 (1992).

arrangement constitutes an "employee welfare benefit plan." In 1980, the federal Fifth Circuit held that "bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits" are not governed by ERISA. Taggart Corp. v. Life & Health Benefits Admin., supra. In deciding Taggart the Court was careful to consider ERISA's purpose and legislative history. The Court determined ERISA's purpose would not be served in the Taggart case because the plan at issue did not have any assets which ERISA's safeguards were intended to protect.

However, since 1980, the federal Fifth Circuit has severely limited the Taggart holding by factually distinguishing Taggart on the fact it involved a corporation with only one employee who was essentially purchasing insurance for himself and his family, as opposed to purchasing insurance for a group of employees, through a multiple employer trust. We find this factual distinction as the reason for the more recent federal Fifth Circuit cases not to follow Taggart inappropriate. The factual distinction disregards the purpose and legislative history of ERISA which was so carefully considered by the Court in Taggart.

The later federal cases, while refusing to overrule the "bare purchase" analysis of Taggart, hold that the purchase of a group policy along with the payment of premiums offers "substantial evidence" that a plan has been established. But, the Court admits the mere payment of premiums is insufficient to create an ERISA plan. See Kidder v. H&B Marine, Inc., 932 F.2d 347 (5th Cir. 1991), and Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). In focusing on the employer-employee-plan relationship, the Fifth Circuit Court has apparently abandoned its focus on whether the "plan" is a trust that has assets which are to be protected by the ERISA safeguards.

Because we believe the later federal Fifth Circuit cases are not in accord with Congressional intent, we decline to follow them and instead adhere to the "bare purchase" rationale of Taggart without making what appears to be inconsequential factual distinctions. In Taggart, the employer purchased a group insurance policy through a multiple employers trust (MET). The employer paid its premiums to the MET which in turn forwarded the premiums to an insurer. The employer did not participate in the day-to-day operations or administration of the MET.

In this case, Coast purchased a group insurance policy from a commercial insurance company, Blue Cross. Coast paid premiums directly to Blue Cross. Blue Cross controlled and administered the policy and its benefits. The group insurance policy was nothing more than a bare purchase of health insurance. There is no evidence Coast owned, controlled or assumed responsibility for the policy. Thus, we find Coast's MEP does not constitute an ERISA plan and, therefore, ERISA does not apply.[9]

ISSUE TWO: Was Richard Kornman covered as a dependent under the terms of the Blue Cross policy during his treatment at the Coliseum?

Coast changed its health insurance coverage from the Chamber plan to Blue Cross in July 1984. Under the Chamber plan, Richard was listed as a dependent of Charlie Kornman. When Coast first obtained group health insurance from Blue Cross, Charlie inadvertently failed to list Richard as a dependent.

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[9] Because we find ERISA does not apply, we need not address appellant's ERISA related issues of whether the Coast MEP is an indispensable party, whether plaintiffs' suit is premature for failure to exhaust administrative remedies provided for in the MEP and whether plaintiffs' state law claims for penalties is preempted by ERISA.

As a result, Carol Rodgers, the Coast employee in charge of the administrative aspects of the company's health insurance plan, sent a letter dated January 21, 1985 to Blue Cross requesting Richard be added as Charlie's dependent. Ten days later, the request was denied by Blue Cross.

We are presented with the question of whether Richard qualified as a dependent under the terms of the policies. The first Blue Cross policy, dated 1984, defined a dependent as:

> "Dependent" means a Member for whom current fees have been paid, and who is the Employee's spouse or a Member who depends on the Employee or his spouse for his support as either his:
>
> 1. Unmarried child under 19 years of age;
>
> 2. Unmarried child 19 to 25 years of age who is enrolled as a full time student;
>
> 3. Unmarried child who becomes mentally or physically disabled prior to attaining the limiting age stated in Article I, 1 and/or I, 2 above and/or who is incapable of self-support.
>
> A Member who depends upon the Employee or his spouse for his support must meet the criteria of I, 1 through 3 above, but, to the extent that the above criteria do not conflict, a Member must also qualify as the Employee's or Employee's spouse's Dependent for purposes of the most current calendar year's federal income tax laws and regulations.
>
> (Plaintiff's Exhibit 3).

The July 1985 Blue Cross policy defined a dependent as:

> "Dependent" means a Member for whom current fees have been paid and is:
>
> the Employee's legal spouse; and
>
> any unmarried child who:
>
> --- is under 19 years old;
>
> --- is 19 years old but less than 25 years old, if enrolled in school as a full-time student in a secondary school, college, university, vocational, technical, trade school or institute and primarily supported by the Employee.
>
> --- is mentally or physically disabled prior to attaining either one of the limiting ages shown above and who is incapable of self-support.
>
> --- qualifies as the Employee's or Employee's spouse's dependent for purposes of the most current calendar year's federal income tax laws and regulations.
>
> (Blue Cross' Exhibit 20).

And, the July 1987 Blue Cross policy definition of a dependent is identical to the 1984 definition.

Was Richard capable of self-support?

We do not see any substantial difference in the definition of a dependent between the policies. In July 1984, when Coast's

employees' health insurance was first covered by Blue Cross, Richard was 24 years old and not a full-time student. Therefore, the question is whether he was mentally or physically disabled and/or incapable of self-support. Plaintiffs assert "incapable of self support" refers to one's inability for self-sustaining employment. On the other hand, defendant maintains as long as a person has money on which to live, he is capable of self-support. There is no definition for "incapable of self-support" in the contract.

Plaintiffs maintain Richard had a drug problem since high school which rendered him incapable of self-support over the years prior to his hospitalization in that he could not hold a regular job, stay in school, or manage his money. Specifically, his mother, Janette Kornman, testified Richard was expelled from Country Day in high school for drug abuse in 1977. His drug abuse continued over the years and his parents sought help for him several times. Ms. Kornman explained Richard's sporadic job history. She stated she and her husband paid Richard's living expenses, including rent and food, and had to bail him our of his bills several times. Richard himself testified his meals and rent were provided by his parents and he would use any money he had to buy drugs. In summary, Mrs. Kornman testified Richard was never in any condition to support himself. Dr. Weisler, Richard's treating psychiatrist at the Coliseum, testified Richard's drug abuse affected his ability to manage his life. Dr. Weisler was of the opinion Richard was not capable of self-sustaining employment.

Defendant focuses on the fact Richard had a steady income over the years before his hospitalization and that income proves he is capable of self-support. However, the record shows the income was largely owed to his parents. Richard had bank accounts in his name which were set up by his father, Charlie. Richard did not have access to the accounts as they were controlled by his mother and father. Mrs. Kornman explained the

accounts were set up for each of the four kids to pay for college tuition and give the kids a head start on life when they finished school but the accounts were maintained and controlled strictly by her husband. The deposits into the accounts included dividend payments from companies set up by Charlie of which the kids were given a percentage. Furthermore, Richard testified when he made money, he spent it on drugs. Richard also stated the last few paychecks he received prior to entering the Coliseum were kept by his father.

The dictionary definition of self-support is "independent support of oneself." Webster's Collegiate Dictionary, Tenth Edition. Independent means not relying on something or someone else. The record shows Richard was financially supported by his parents. The record also shows his drug abuse impaired his ability to manage his life including his health and money. The mere fact Richard had accounts in his name with substantial amounts of money is not axiomatic for his ability to support himself. There is ample testimony showing Richard did not have access to the money. Without the money, he necessarily relied on his parents for food and payment of rent and other bills. Even if Richard had access to the money, we cannot say he was capable of self-support. He admitted the money he did have went to buying more drugs. Defendant points out Richard successfully attended a six-month kibbutz program in Israel where he remained drug free. However, we do not find a six-month period in 1980 to be indicative of whether Richard is capable of self-support in 1984, when the Blue Cross policy went into effect. Richard suffered from a drug addiction that severely impaired his ability to manage his life.

Defendant argues Richard still cannot be a dependent because he did not qualify nor was he claimed as a dependent on his parents' federal tax return as required by the policy. The language of the policy states "to the extent that the above criteria

do not conflict, a Member must also qualify as the Employee's . . . Dependent for purposes of the . . . federal income tax laws and regulations." Insofar as Richard could not qualify as a dependent for federal tax purposes, we find such federal provision conflicts with the policy and, therefore, according to the very terms of the policy, the provision is inapplicable.

Was Charlie Kornman required to provide proof of Richard's incapacity and dependency when Richard reached 25, the limiting age?

Defendant next maintains Charlie was required to provide proof of Richard's disability when Richard turned 25-years-old in December 1985 pursuant to La. R.S. 22:215.2(A). La. R.S. 22:215.2(A) provides:

> A. Any hospital or medical expense insurance policy delivered or issued for delivery in this state more than ninety days after July 12, 1973, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self sustaining employment, and (2) chiefly dependent upon the policyholder, employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the

child's attainment of the limiting age.

We find the proof aspect of the statute was not the objective of the legislature in enacting the law but rather the primary intent was to require insurance companies to cover dependent children who have reached the limiting age for said children within the terms of the policy but who remain incapable of self-sustaining employment and are dependent for their support. The statute allows the insurance company to require proof of such incapacity and dependency as an ancillary. While Blue Cross included the requisite coverage, it did not mandate the proof element. We find Blue Cross effectively excluded the proof element of the statute and such exclusion does not thwart the intent of the law. Thus, Charlie was not required to provide proof of Richard's dependency where such proof was not requested by Blue Cross.

Could Blue Cross have denied Richard coverage based on information in a health questionnaire?

Defendant raises yet another issue regarding Richard's qualification as a dependent. Defendant asserts material misrepresentations were made by Charlie concerning Richard's prior health problems when he submitted the "Change of Status Form" attempting to add Richard as a dependent. Specifically, Byron Gorman, an insurance claims adjuster for Blue Cross, testified that had Richard's health questionnaire indicated he had a previous drug problem, he would have been rejected outright.

However, La. R.S. 22:215(A)(1)(a) precludes an insurer from issuing a group health insurance plan that allows for individual selection. Since Blue Cross could not legally exclude Richard from coverage, we find it unnecessary to determine whether material misrepresentations were made.

Having found Richard qualified as a dependent, we turn

our analysis to whether his treatment at the Coliseum was covered.[10]

ISSUE THREE: Was Richard's treatment at the Coliseum covered by the terms of the policy?

Did Richard's treatment at the Coliseum fall during the 365-day exclusion period for pre-existing conditions?

Defendant alternatively asserts if Richard was a qualified dependent, there was a 365-day waiting period for subsequent enrollees for pre-existing conditions. All three policies, 1984, 1985 and 1987, provided a 365-day waiting period for pre-existing conditions for subsequent enrollment which began to run from the original effective date. Mildred Echlin, an employee of Blue Cross, testified she reviewed Richard's claim and denied it because his treatment was for a pre-existing condition for which the time delays for coverage had not run.

Plaintiffs concede Richard was left off of Charlie's original enrollment application. Therefore, according to Ms. Echlin's testimony, Richard could not have been considered an initial enrollee and was thus subject to the delays for pre-existing conditions. We accept Richard was a subsequent enrollee subject to the 365-day waiting period for pre-existing conditions.

However, we have determined Richard qualified as a dependent under the July 1984 policy as well as the subsequent 1985 and 1987 policies. Therefore, Richard was a qualified dependent when Charlie sought to add him to his policy in January 1985 and should have been added as such. Thus, even

---

[10] Because we determined Richard was a dependent under the policy, we find no need to address whether he was independently covered as an employee of Coast.

accepting defendant's argument there was a 365-day waiting period for coverage of Richard's pre-existing condition of substance abuse, that period expired in January 1986 at which time Richard was afforded full coverage. Richard was hospitalized in May 1987 through April 1988. It is clear Richard was afforded coverage for his treatment during the time he was hospitalized.

Was Richard treated for substance abuse or for a mental condition for which there is a policy limit of $5,000?

Defendant claims the maximum amount of benefits plaintiffs can recover is $5,000 because Richard's treatment was for a mental disorder for which there is a $5,000 policy limit. Since Richard was hospitalized in May 1987, the governing policy is the July 1985. The policy provided:

> After the applicable Comprehensive Medical Expense Deductible as shown in the Schedule of Benefits has been met, We agree to pay for the treatment of mental and nervous disorders, the coinsurance percentage shown in the Schedule of Benefits for mental and nervous incurred by each Member, not to exceed the applicable Limit of Liability shown for mental and nervous in the Schedule of Benefits.

Byron Gorman, a former employee of Blue Cross, testified the policy limits for a mental disorder was $5,000.

Dr. Weisler, Richard's treating psychiatrist at the Coliseum, testified drug abuse was the primary cause of Richard's problems which included at times psychotic like symptoms. Dr. Weisler further stated there were many symptoms that resulted from Richard's drug abuse including problems relating to people and managing his life. During cross-examination, Dr. Weisler was presented with some results of psychological tests concern-

ing Richard's condition. The tests indicated Richard suffered from some sort of psychotic illness which is a mental disorder. However, Dr. Weisler explained these tests are not a diagnosis but rather explain the condition of the patient. Although asked numerous times on cross-examination, Dr. Weisler emphatically denied Richard's condition as being one of a mental disorder. When Richard was admitted to the Coliseum, his records indicate his diagnosis was borderline personality disorder which Dr. Weisler admits is a mental disorder. However, we are convinced and accept the explanation of Dr. Weisler that Richard's primary problem was substance abuse which led to secondary problems. And while Richard may have been treated for secondary problems, we believe his primary treatment was for substance abuse which is the reason he was judicially committed.

Was Richard's treatment at the Coliseum medically necessary?

The 1985 policy defines "medically necessary" as Health Care services which:

> are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Louisiana, could not have been omitted without adversely and severely affecting the patient's condition;
>
> are not primarily Custodial Care;
>
> are appropriate and can be safely used under the circumstances. Inpatient Hospital Services should be used only when a lesser equipped facility (e.g. Outpatient Hospital Services, Physician's office, etc.) could adversely and severely affect the patient's condition.

The 1987 policy provided basically the same definition:

> "Medically Necessary" means a service or treatment which, in the judgment of the Plan:
>
> 1. Is appropriate and consistent with the diagnosis and which in accordance with accepted medical standards in the State of Louisiana could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
>
> 2. Is not primarily Custodial Care; and
>
> 3. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient's condition or quality of medical care rendered.

In arguing Richard's treatment at the Coliseum was not medically necessary, defendant relies on the testimony of its expert, Dr. Olivier. However, we note Dr. Olivier's testimony was rejected by the trial court and is in the record through a proffer. However, defendant did not raise as an issue on appeal that the exclusion of Dr. Olivier's testimony was erroneous. Therefore, we cannot consider the proffered testimony.

Considering the record, we find Richard's treatment was medically necessary. It is absurd to argue Richard's condition would not have been adversely and severely affected if he had not received treatment at the Coliseum. Furthermore, after unsuccessfully being treated on an outpatient basis by various psychiatrists and doctors, we do not find Richard's condition could have been treated at a lesser facility.

CONCLUSION

We find Coast's MEP was not an ERISA plan. Later federal jurisprudence which severely restricts the holding of Taggart, which was relied on by the Eastern District and the trial court in determining Coast's MEP was not an ERISA plan, is not binding on us as a state court bur rather is merely persuasive. For the reasons above, we decline to follow the more recent federal jurisprudence due to our opinion it disregards the Congressional intent behind ERISA's enactment. We adhere to the rationale and the "bare purchase" test of Taggart and find Coast's MEP was nothing more than a bare purchase of health insurance for its employees.

After reviewing the terms of the Blue Cross policies, we find Richard Kornman was covered as a dependent of Charlie Kornman because he was incapable of self-support. Thus, Richard should have been added to Charlie's policy in January 1985 when he so requested it. We find proof of Richard's dependency was not required absent a request by Blue Cross. And, because we find Blue Cross could not have legally denied Richard coverage on the basis of his health, the issue of whether material misrepresentations were made on his health questionnaire is of no consequence.

Being added after the initial enrollment date of July 1984, Richard was a subsequent enrollee who was subject to the 365-day time delay for coverage of pre-existing conditions. However, the time delay had expired when Richard was hospitalized in May 1987. Thus, he was covered for treatment of substance abuse during the time he was hospitalized.

We find Richard's treatment was for substance abuse and not a mental disorder and, therefore, the policy limit of $5,000 for treatment of mental disorders is inapplicable. And, we find

Richard's treatment at the Coliseum was medically necessary as there was no evidence to the contrary.

For the above reasons, we hereby affirm *in toto* the trial court's judgment dated September 30, 1993 awarding judgment in favor of plaintiffs-appellees.

Appellant is to bear the costs for this appeal.

AFFIRMED

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

JANETTE M. KORNMAN, ET AL	CIVIL ACTION
V.	NO. 88-3102
BLUE CROSS/BLUE SHIELD OF LOUISIANA	SECTION "H" (4)

Order and Reasons

Plaintiffs filed suit in Louisiana state court for benefits allegedly due by defendant under a group insurance policy purchased by Coast Quality Construction Corporation for the benefit of its employees. The case was removed to this court by defendant on the ground that the action is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq. Plaintiffs maintain that the action is not governed by ERISA and move to remand the case to state court. For the following reasons, the motion is GRANTED.

The only issue presented by the motion is whether the insurance policy in question constitutes an "employee welfare benefit plan" within the meaning of ERISA. 29 U.S.C. §1002(1) defines "employee welfare benefit plan" as:

any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants, or their beneficiaries, through the

purchase of insurance or otherwise, . . . medical, surgical or hospital care or benefits, or benefits in the event of sickness accident, disability, death or unemployment. . . .

Plaintiffs contend that the insurance policy does not fall within that definition because it does not constitute a "plan, fund, or program." We agree.

The Fifth Circuit has squarely held that ERISA does not cover "bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." Taggart Corp. v. Life & Health Benefits Administration, Inc., 617 F.2d 1208, 1211 (5th Cir. 1980), cert. denied, 450 U.S. 1030 (1981).

The defendant argues that the Taggart case is distinguishable because the employer in that case purchased the insurance through a multi-employer trust. However, in reaching its decision that the mere purchase of insurance did not constitute establishment of a "plan, fund, or program," the Taggart court did not rely on the fact that the insurance was purchased through a multi-employer group. The court's reasoning applies equally to this case. Moreover, defendant's argument raises a distinction without a difference. A purchase of insurance is not more a "plan, fund, or program" because accomplished unilaterally than it is if accomplished through a multi-employer group. In fact, if the distinction makes any difference, it cuts the other way; the existence of an organization as in Taggart to coordinate the purchase of insurance on behalf of a group of employers would make the case better suited to a finding of a "plan, fund, or program."

The defendant cites a number of cases from other circuits and urges the court to apply the reasoning of the Eleventh

Circuit's "seminal" decision in Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (en banc). Suffice it to say that, regardless of the law in other circuits, we are bound by the Fifth Circuit's decision in Taggart.

October 21, 1988

Adrian G. Duplantier
UNITED STATES
DISTRICT JUDGE

APPENDIX D

24TH JUDICIAL DISTRICT COURT FOR THE PARISH OF JEFFERSON

STATE OF LOUISIANA

NO.: 364-688 DIVISION "E"

JANETTE M., WIFE OF/AND CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD KORNMAN

VS.

BLUE CROSS/BLUE SHIELD OF LOUISIANA

FILED: _____ _____
DEPUTY CLERK

JUDGMENT

This matter came before the Court on Exceptions of No Cause or Right of Action, Lack of Procedural Capacity, Non-joinder of a Necessary Party Defendant, Prematurity and Lack of Subject Matter Jurisdiction, all filed on behalf of the defendant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana). A hearing was held on April 19, 1989.

PRESENT: DAVID C. LOEB AND
SUSAN M. CHEHARDY,
ATTORNEYS FOR PLAINTIFFS

SYLVAN J. STEINBERG AND
JULIA S. MANDELLA
ATTORNEYS FOR DEFENDANT

After considering the pleadings, memoranda and argument of counsel, it is hereby

ORDERED that the Exceptions filed herein on behalf of the defendant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana) be and the same are hereby denied.

IT IS FURTHER ORDERED that the defendant file responsive pleadings herein within fifteen (15) days of April 26, 1989.

Gretna, Louisiana, this 26 day of April, 1989.

s/Clarence E. McManus
JUDGE

APPENDIX E

COURT OF APPEAL, FIFTH CIRCUIT
State of Louisiana

Clerk's Office, Gretna November 17, 1995, 198____

DEAR SIR:

REHEARING WAS THIS DAY REFUSED IN THE CASE ENTITLED

Janette M. Kornman v. Blue Cross/Blue Shield of La.

No. 95 CA 310

Very truly yours,

PETER J. FITZGERALD, JR., Clerk

Supreme Court, U.S.
FILED
MAY 7 1996
OFFICE OF THE CLERK

NO. 951817

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

JANETTE M. WIFE OF/AND CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

SUPPLEMENTAL APPENDIX

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LCAPP

APPENDIX F

STATE OF LOUISIANA

COURT OF APPEAL

FIFTH CIRCUIT

DOCKET NO. 94-CA-00306

JANETTE M. wife of/and CHARLIE KORNMAN,
Individually
and on behalf of their dependent son,
RICHARD JAY KORNMAN
Plaintiffs-Appellees

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA
Defendant-Appellant

Appeal from the Twenty-Fourth Judicial District
Court, Parish of Jefferson, State of Louisiana,
Docket No. 364,688, Div. "E",
the Hon. Clarence E. McManus, Presiding

ORIGINAL BRIEF ON BEHALF OF
DEFENDANT/APPELLANT,
LOUISIANA HEALTH SERVICE &
INDEMNITY COMPANY
BLUE CROSS/BLUE SHIELD OF LOUISIANA

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Attorneys for Louisiana Health Service & Indemnity Company (Blue Cross/Blue Shield of Louisiana)

* * *

ASSIGNMENT OF ERRORS

1. The trial court erred when it failed to find that Coast Quality Construction Company provided as a benefit to its employees, including Charlie Kornman, a medical expense plan which was insured by Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana).

2. The trial court erred when it failed to find that the medical expense plan provided by Coast Quality Construction Company to its employees, including Charlie Kornman, was an ERISA plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA").

3. The trial court erred when it failed to find that the claims of plaintiffs-appellees including the claim under La.R.S. 22:657 and other state laws argued by plaintiff-appellees were preempted by ERISA.

4. The trial court erred when it failed to find that the medical expense plan provided by Coast Quality Construction Company to its employees, including Charlie Kornman, was an indispensable party to this suit.

5. The trial court erred when it failed to find that the suit filed by plaintiff-appellees was premature.

* * *

ISSUES PRESENTED FOR REVIEW

1. Whether Coast Quality Construction Company provided as a benefit to its employees, including Charlie Kornman, a medical expense plan which was insured by Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana)?

2. Whether the medical expense plan provided by Coast Quality Construction Company to its employees, including Charlie Kornman, is an ERISA plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA")?

3. Whether the claims of plaintiffs-appellees including the claim under La.R.S. 22:657 and other state laws argued by plaintiff-appellees are preempted by ERISA?

4. Whether the medical expense plan provided by Coast Quality Construction Company to its employees, including Charlie Kornman, is an indispensable party to this suit?

5. Whether the suit filed by plaintiff-appellees is premature?

* * *

ARGUMENT

I. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) GOVERNS THIS MATTER

A. *The Medical Expense Plan Under Which Plaintiffs-Appellees Claim Entitlement to Benefits is an ERISA Plan.*

The trial court erred in finding that the plan under which the plaintiffs-appellees claim entitlement to benefits is not an ERISA plan. Coast established a medical expense plan insured by Blue Cross for its employees. Charlie Kornman enrolled himself and his wife, Janette, in the medical expense plan as an employee of Coast. See, Blue Cross Exhibit "2". Initially Charlie Kornman did not attempt to enroll Richard Kornman as a dependent. Testimony of J. Kornman, Transcript at pp. 1982-83; Testimony of D. Epstein, Transcript at pp. 942-944, 1014. Later he attempted to qualify Richard Kornman as his dependent under this plan. See, Blue Cross Exhibit "3". Alternatively, plaintiffs-appellees claim that Richard Kornman, individually, enrolled in the plan as an employee of Coast.

The medical expense plan under which plaintiffs claim they are entitled to benefits is, in reality, an "employee welfare benefit plan" as defined by ERISA. 29 U.S.C. §1002(1). An ERISA plan is defined as:

> any plan, fund or program . . . established by an employer or employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of the insurance or otherwise, (A) medical, surgical or hospital care or

> benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

See, 29 U.S.C. §1002(1). The medical expense plan Coast established for its employees clearly qualifies as an ERISA plan under the language of the statute, because it is a program established by Coast for the purpose of providing medical, surgical or hospital benefits in the event of sickness or accident to the employees of Coast. Additionally, the Coast plan qualifies as an ERISA plan in light of recent decisions by the U. S. Fifth Circuit as to what constitutes an ERISA plan.

The Fifth Circuit of the United States Court of Appeals has found that employer's involvement in the plan determines whether a plan meets the requirements to establish an ERISA welfare benefit plan. See, Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 242-43 (5th Cir. 1990); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016-17, n.2 (5th Cir. 1993), cert. den'd, __ U.S.__, 113 S.Ct. 2455, 124 L.Ed.2d 671.

In Rodriguez, the employees contributed, through payroll deductions, a portion of the insurance premiums; the employer paid the balance. The Fifth Circuit specifically held in Rodriguez that such an arrangement and involvement by the employer established an ERISA plan. Rodriguez, 980 F.2d at 1017, n.2. Likewise, a similar arrangement by the employer was found sufficient in the Memorial Hospital case to establish an ERISA plan. Memorial Hospital, 904 F.2d at 242-43. The Fifth Circuit noted that "[t]he fact that [an employer's] administrative functions over the policy are minimal is perfectly in keeping with the intent that [the insurer] administer the plan as well as insure it." Id.

The Coast plan is exactly the same situation that occurred in Rodriguez and Memorial Hospital. The Coast employees con-

tributed, through payroll deductions, a portion of the insurance premiums; Coast paid the balance. See, Testimony of D. Epstein, Transcript at pp. 987- 89. The Fifth Circuit has specifically held that such a plan qualifies as an ERISA benefit plan. The trial court was, therefore, incorrect in holding that ERISA does not apply to this matter.

The plaintiffs-appellees rely heavily upon Taggart Corp. v. Life & Health Benefits Adm., Inc., 617 F.2d 1208 (5th Cir. 1980), cert. den'd sub nom, Taggart Corp. v. Efros, 450 U.S. 1030 (1981). Taggart is inapposite in this matter. In Taggart, a corporation with one employee purchased an interest in a multi-employers' trust. Employers who had too few employees to qualify for group insurance rates would subscribe to the trust and become members of the trust group of subscribers. The Fifth Circuit held that ERISA was inapplicable, not because a group insurance policy was involved, but because the multi-employers' trust was not established by an employer and/or employee organization, as those terms are defined by ERISA. Taggart, 617 F.2d at 1210. Plaintiffs-appellees errantly rely on Taggart for the proposition that bare purchases of health insurance do not qualify as an ERISA plan. However, putting the Fifth Circuit's statement in context, the Fifth Circuit actually held:

> Considering the history, structure and purpose of ERISA, we cannot believe that the Act regulates bear purchases of health insurance, where, as here, the purchasing employer neither directly or indirectly owns, controls, administers or assumes responsibility for the policy or its benefits.

Id. at 1211 (emphasis added). In this case, Coast clearly, as purchasing employer, directly owned, controlled, administered and/or assumed responsibility for the policy and its benefits. Coast administered the payroll deductions for the employees'

contribution for their portion. Coast additionally assumed responsibility for the policy by committing to pay the balance of the insurance premiums. Testimony of D. Epstein, Transcript at pp. 987-89; see also, Testimony of M. Echlin, Transcript at p. 1730. The Fifth Circuit finds that such an arrangement is sufficient for the necessary employer relationship to constitute an ERISA plan. See, Rodriguez, 980 F.2d at 1017, n.2; Memorial Hosp., 904 F.2d at 242-43. Moreover, while the bare purchase of an insurance policy does not necessarily establish the existence of an ERISA plan, the U.S. Fifth Circuit Court of Appeals has recently held that an employer's payment of premiums on behalf of its employees is substantial evidence that a plan, fund or program under ERISA was established. See, Kidder v. H & B Marine, Inc., 932 F.2d 347 (5th Cir. 1991).

The trial Testimony of Mr. David Epstein, an employee of Coast who arranged for the plan, demonstrates that Coast desired and chose to provide health benefits for its employees, chose the coverage it would provide, paid a percentage of each employee's premium, deducted the remaining percentage from each employee's paycheck, and was responsible for submitting the premiums to Blue Cross each month. See, Testimony of D. Epstein, Transcript at pp. 987-89.

Contrary to the plaintiffs' assertions, a formal document designated as "the plan" is not required to establish the existence of an ERISA plan. Otherwise, employers could avoid federal regulation merely by failing to memorialize their employee benefit programs in a separate document designated as such. See, Donovan v. Dillingham, 688 F.2d 1367, 1373 n.5 (11th Cir. 1982) (en banc). It is irrelevant whether Coast intended to create an ERISA plan. Coast intended to provide a means by which its employees would receive medical benefits and payment of medical claims. Because the Coast plan is an ERISA plan, plaintiffs are limited in their relief to the civil enforcement

provisions of ERISA. See, 29 U.S.C. §1132. See also, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39, 50-51 (1987).

B. *The Medical Expense Plan Established by Coast is an Indispensable Party*

The trial court erred in holding that the ERISA plan, itself, established by Coast was not an indispensable party. The civil enforcement provisions of ERISA are contained in 29 U.S.C. §1132. Section 1132(d) makes clear that an ERISA plan "may sue or be sued . . . as an entity." The statute goes on to state that: "Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability is established in his individual capacity under this subchapter." 29 U.S.C. §1132(d)(2). Where plaintiffs are seeking to recover benefits allegedly due to them under the terms of an ERISA plan, the proper defendant is the plan, which may be sued as an independent entity pursuant to 29 U.S.C. §1132(d)(1). Jourdan v. Claims, Inc., 1992 U.S. Dist. LEXIS 2157 (W.D Mich. 1992); Jenkinson v. Chevron Corp., 634 F. Supp. 375, 377 (N.D. Cal. 1986). See, attached Exhibit "B". Therefore, the ERISA plan established by Coast is an indispensable party to the suit filed by plaintiffs-appellees, and thus, this matter should be dismissed for plaintiffs-appellees' failure to join the ERISA plan established by Coast as a proper party defendant.

C. *Plaintiffs-Appellees' Lawsuit is Premature*

The trial court erred in holding that the instant lawsuit was not prematurely filed. Pursuant to the terms of the ERISA plan established by Coast, as set forth in the plan summary, if the plaintiffs-appellees believe that their claims were improperly

denied, they should have filed an appeal with the ERISA review department of Blue Cross within sixty days after the plan mailed a written notice of denial of the claim. See, Plan Summary for 1984, Plaintiffs Exhibit "3", p. 15, Employee Booklet; Plan Summary for 1985, Plaintiffs Exhibit 4, p. 26, Employee Booklet; Plan Summary for 1987, Plaintiffs Exhibit 6, P. 15, Employee Booklet. The plaintiffs-appellees have never filed such an appeal. Their suit is, therefore, premature and should be dismissed since the plaintiffs-appellees failed to exhaust their administrative remedies under the ERISA plan.

The U.S. Fifth Circuit Court of Appeals has recently reaffirmed its holding that a failure to exhaust the administrative remedies provided for in an ERISA plan forecloses judicial review of the claim denial. Rodriguez, 980 F.2d at 1016 n.1. See also, Denton v. First Nat'l Bank, 765 F.2d 1295, 1300-03 (5th Cir. 1985); Taylor v. South Central Bell, 422 So.2d 528, 29 (La.App. 5th Cir. 1982), citing, Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980); Steeg v. Lawyer's Title Insurance Corp., 329 So.2d 719 (La. 1976) ("It is well-established that the failure to pursue and exhaust administrative remedies precludes judicial relief."). As one court has noted, administrative responsibility rests with those whose experience is daily and continual, and not with judges whose exposure is episodic and occasional. Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985).

In Rodriguez, an employee was attempting to collect benefits provided to him by his employer through Pacificare, a health maintenance organization (HMO). Pacificare denied the employee's claim for care received outside his HMO plan. The plaintiff bypassed the administrative procedures for contesting the claim denial and filed suit in state court. The Fifth Circuit upheld summary judgment against Rodriguez noting that the deadline for Rodriguez to use the grievance procedures outlined in the ERISA plan had long since passed; therefore, the Fifth

Circuit refused to remand the case, stating that such action would have been futile. Rodriguez, 980 F.2d at 1016 n.1.

In this case, the plaintiffs failed to exhaust their administrative remedies before filing suit in state court. Such a failure to exhaust administrative remedies provided for in the ERISA plan forecloses judicial review of the claim denial. Rodriguez, 980 F.2d at 1016 n.1. The deadlines for the plaintiffs to use the plan's grievance procedure has long since passed; therefore, any action to remand this case would now be futile and plaintiffs-appellees' suit should be dismissed. See, Plan Summary for 1984, Plaintiffs Exhibit "3", p. 15, Employee Booklet; Plan Summary for 1985, Plaintiffs Exhibit 4, p. 26, Employee Booklet; Plan Summary for 1987, Plaintiffs Exhibit 6, P. 15, Employee Booklet.

D. *Plaintiffs-Appellees' State Law Claims are Preempted*

The trial court erred in finding that the plaintiffs'-appellees' state law claims were not preempted by ERISA. Plaintiffs'-appellees' sole basis for recovery is alleged violations of state law and Louisiana Revised Statutes. Plaintiffs-appellees also contend that they are entitled to penalties and attorneys fees pursuant to La.R.S. 22:657. This statute is completely preempted by ERISA's civil enforcement provision, 29 U.S.C. §1132. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d, 39, 51 (1987). In Pilot Life, the Supreme Court held that the civil enforcement provisions of ERISA were intended by Congress to be the "exclusive vehicle for action by ERISA-plan participants and beneficiaries asserting improper processing of claims for benefits, and that the varying state causes of action for claims within the scope of [section] 1132 would pose an obstacle to the purposes and objectives of Congress." Pilot Life, 95 L.Ed.2d at 50-51. The Supreme Court further noted that:

> Policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in [section 1132] of the statute as finally enacted . . . provides strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. at 52, quoting, Massachusetts Life Ins. Co. v. Russell, 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985).

Louisiana Revised Statute 22:657 clearly provides a remedy to participants and beneficiaries claiming benefits which was not intended nor provided by 29 U.S.C. §1132. ERISA contains no provision for punitive damages. Russell, 473 U.S. at 144. Therefore, both Louisiana state courts and federal courts have been uniform in holding that ERISA preempts Louisiana Revised Statute 22:657. Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990), cert. den'd, 499 U.S. 938 (1991). See also, Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 109-110 (5th Cir. 1993); West v. Connecticut General Life Ins. Co., 591 So.2d 1296 (La. App. 3d Cir. 1991); Taylor v. Blue Cross/Blue Shield of New York, 684 F. Supp. 1352, 1356-59 (E.D. La. 1988). Moreover, plaintiffs'-appellees' assertion that preemption only applies in the context of self-funded ERISA plans, is clearly wrong. The United States Supreme Court specifically held in Pilot Life that ERISA's preemption provisions apply in the context of an insured employee benefit plan. Pilot Life, 95 L.Ed.2d at 45 and 51-52. See also, Cramer, 569 So.2d at 533 (Louisiana Supreme Court likewise applied ERISA's preemption provisions to an insured plan).

Moreover, ERISA preempts all state laws which "relate to" an ERISA plan. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); 29 U.S.C. §1144(a); Cramer v. Association Life Ins. Co., 569 So.2d 533, 535 (La. 1990). Traditional state law contract claims against an employee benefit plan regulated by ERISA are preempted by ERISA. Pilot Life, 95 L.Ed.2d at 52. See also, West v. Connecticut General Life Ins. Co., 591 So.2d 1296, 1297 (La. App. 3d Cir. 1991). A state law which "relates to" an employee benefit plan will be "saved" from preemption if it regulates insurance. 29 U.S.C. §1144(b)(2)(A). See also, Cramer, 569 So.2d at 535. However, even if a state law "regulates insurance" it will still be preempted if application of the state law would effectively "deem" an employee benefit plan to be an insurer. 29 U.S.C. §1144(b)(2)(B). The Louisiana Supreme Court discussed the relationship of ERISA to state insurance laws:

> Recognizing that the broad provisions of ERISA overlap with numerous state regulatory laws, Congress put in ERISA three provisions relating to the preemptive effect of the federal legislation, often referred to as the preemption clause, the savings clause and the deemer clause. The preemption clause states:
>
> > except as provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan . . . (*emphasis added*). [29 U.S.C. §1144(a)]
>
> The savings clause states:
>
> > except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed

> to exempt or relieve any person from any law of any state which *regulates insurance*, banking or securities. (*emphasis added*). [29 U.S.C. subsection 1144(b)(2)(A)]

The deemer clause states:

> neither any employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the *business of insurance* . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts . . . (*emphasis added*). [29 U.S.C. subsection 1144(b)(2)(B)].

Cramer, 569 So.2d at 535. The Louisiana Supreme Court stated that the deemer clause, the savings clause and the preemption clause generally work as follows: "If a state law relates to employee benefit plans, it is preempted unless the law regulates insurance, in which case the savings clause saves the law from preemption; but, a state law that purports to regulate insurance may not deem an employee benefit plan to be an insurance company." Id.

The term "relates to" is expansive and should be read in its broad common-sense meaning such that a state law relates to a plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." West, 591 So.2d at 1298, quoting, Shaw v. Delta Airlines, 463 U.S. at 96-97. See also, Cramer, 569 So.2d at 536.

As used in the savings clause, the term "regulates insurance" means that a state law "must not just have an impact on the insurance industry, but must be specifically directed towards that industry." West, 591 So.2d at 1298, quoting, Pilot Life, 95

L.Ed.2d at 49. The savings clause saves from preemption those state laws which regulate the "business of insurance" as that phrase is defined by the case law interpreting the McCarron-Fergerson Act. Pilot Life, 95 L.Ed. 2d at 48. The Supreme Court has adopted three criteria in interpreting the phrase "business of insurance":

> (1) whether the practice has the effect of transferring or spreading a policyholder's risk;
>
> (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and
>
> (3) whether the practice is limited to entities within the insurance industry.

West, 591 So.2d at 1298; Taylor, 684 F.Supp. at 1358-59. See also, Pilot Life, 95 L.Ed. 2d at 48; Cramer, 569 So.2d at 537-38. Finally, the deemer clause provides that an ERISA plan shall not be "deemed by any state law to be an insurance company, to be engaged in the business of insurance, or to be an insurance contractor for purposes of applying the savings clause." Pilot Life, 95 L.Ed 2d at 46.

The trial court erred in finding that even if ERISA did apply to this case, it would not have altered the outcome of this matter as to coverage. Using the analysis outlined above with regards to the deemer clause, savings clause and preemption clause, Louisiana state courts and federal courts have found that Louisiana Revised Statute 22:657 has been preempted by ERISA. The trial court was in error where it held that ERISA would only preempt Louisiana Revised Statute 22:657 and would not affect

the other insurance laws relied upon by plaintiffs-appellees. Other statutes relied upon by the plaintiffs in this case are also preempted. Using the preemption analysis above, courts have found that ERISA preempts Louisiana Revised Statute 22:619(B)[1], another statute relied upon by the plaintiffs-appellees. Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105 (5th Cir. 1993). Additionally, the Fifth Circuit noted that other courts have held that the case law holding that ambiguous terms in an insurance contract are to be construed against the insurer is also preempted by ERISA. Tingle, 996 F.2d at 110 n.25, citing, McMahan v. New England Mut. Life Ins. Co., 888 F.2d 426, 428-30 (6th 1989). The court applied the three part test and found that the law did not spread policy holder's risk but, instead forces the insurer to bear the legal risk associated with the ambiguous policy language. Id. Additionally, the court noted that the law was not aimed directly at the insurance industry because it derived from state law. Id. See also, Brewer v. Lincoln National Life Ins. Co., 921 F.2d 150 (8th Cir. 1990), cert. den'd, __ U.S. __, 111 S.Ct. 2872, 115 L.Ed.2d 1038 (1991) (Missouri law requiring that ambiguities in insurance contracts be construed against insurer is preempted by ERISA). The trial court's finding that the plaintiffs' state law claims have not been preempted by ERISA is clearly incorrect, since the plaintiffs-appellees' pleadings allege only violations of state law and statutes which have been preempted by ERISA; therefore, the Judgment of the Court should be reversed and the plaintiffs-appellees' suit dismissed.

---

[1] Louisiana Revised Statute 22:619(B) provides:

In any application for life or health insurance made in writing by the insured, all statements made therein by the insured shall, in the absence of fraud, be deemed representations and not warranties. The falsity or any such statement shall not bar the right to recovery under the contract unless such false statement was made with actual intent to deceive, or unless it materially effected either the acceptance of the risk or the hazard assumed by the insurer.

West, 591 So.2d at 1299; Rodriguez, 980 F.2d at 1016 n.1.

* * *

CONCLUSION

In conclusion, Blue Cross asserts that the medical expense plan adopted by Coast and insured by Blue Cross qualifies as an ERISA plan. For this reason, Blue Cross submits that ERISA governs this matter. Under ERISA, plaintiffs-appellees' suit is premature. Also, plaintiffs-appellees have failed to join an indispensable party, the medical expense plan, itself. Additionally, plaintiffs-appellees' suit is based upon state law claims which have been preempted by ERISA.

* * *

Accordingly, it is respectfully submitted that the Judgment of the trial court should be reversed and judgment entered in favor of defendant-appellant, Blue Cross.

Respectfully submitted:
s/Sylvan J. Steinberg

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the above and foregoing Appellant Brief has been served on Marion F. Edwards, Esq., Post Office Box 81, Gretna, LA. 70054, and David Charles Loeb, Esq., 3445 North Causeway Blvd., Suite 103, Metairie, LA. 70002, by hand, facsimile, or by U.S. Mail, postage prepaid and properly addressed, this 13th day of June, 1994.

s/Sylvan J. Steinberg
SYLVAN J. STEINBERG

APPENDIX G

COURT OF APPEAL

FIFTH CIRCUIT

STATE OF LOUISIANA

DOCKET NO. 94-CA-306

JANETTE M. wife of/and CHARLIE KORNMAN,
Individually
and on behalf of their dependent son,
RICHARD JAY KORNMAN

Plaintiffs-Appellees

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

Defendant-Appellant

Appeal from the Twenty-Fourth Judicial District
Court, Parish of Jefferson, State of Louisiana,
Docket No. 364,688, Div. "E",
the Honorable Clarence E. McManus, Presiding

APPLICATION BY DEFENDANT-APPELLANT LOUISIANA HEALTH SERVICE AND INDEMNITY COMPANY (BLUE CROSS/BLUE SHIELD OF LOUISIANA) FOR REHEARING

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APPLICATION BY DEFENDANT-APPELLANT FOR REHEARING

NOW INTO COURT, through undersigned counsel, comes Louisiana Health Service and Indemnity Company (Blue Cross/ Blue Shield of Louisiana), defendant-appellant, who respectfully represents that the Judgment of this Honorable Court rendered herein on the 26th day of September, 1995, affirming the Judgment of the Twenty-Fourth Judicial District Court for the Parish of Jefferson, State of Louisiana awarding Judgment in favor of plaintiffs-appellees and ordering defendant-appellant to bear the costs of appeal is in error, contrary to the law, contrary to the evidence and prejudicial to the defendant-appellant for the following reasons:

1.

This Honorable Court is in error in holding that the medical expense plan (MEP) established by the employer, Coast Quality Construction Company (hereinafter called "Coast") for its employees is not an employer medical expense plan as defined by the Employee Retirement Income Security Act (ERISA). As more fully set forth in the brief made part of this Application for Rehearing, in so holding, this Court is in conflict with the Court of Appeal, First Circuit, State of Louisiana in the case of Cramer v. Association Life Insurance Company, 563 So.2d 267 (La.App. 1st Cir. 1990). The Louisiana Supreme Court did not reverse the First Circuit finding and holding that the MEP in that case was an ERISA plan. In fact the Louisiana Supreme Court followed the findings and holding of the First Circuit to hold that ERISA preempted state law. Cramer v. Association Life Insurance Company, 569 So.2d 533 (La. 1990), cert. denied, 499 U.S. 938 (1991). This Court is also in conflict with the Court of Appeal, Third Circuit, State of Louisiana in the case of West v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La.App. 3rd Cir. 1991). The Third Circuit in the West case held the plan to be an ERISA plan. Also as more fully set forth in said brief, this Court is in error because it found that there was no trust for ERISA to protect and that there was no evidence that Coast owned, controlled or assumed responsibility for the plan and policy. The Court is in error in following the case of Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980) cert. denied 450 U.S. 1030 (1981). Taggart is a U.S. Fifth Circuit decision that this Honorable Court follows but it declines to follow later U.S. Fifth Circuit decisions that distinguish it. The later U.S. Fifth Circuit cases relied on by defendant-appellant do not disregard the purpose of ERISA but adhere to it in factual situations that ERISA was intended to apply to. It is submitted that the Coast MEP for its employees was an ERISA plan. This Honorable Court should have considered whether the Coast

MEP is an indispensable party, whether plaintiffs suit is premature for failure to exhaust administrative remedies and whether the state law relied on by plaintiffs-appellees is preempted by ERISA.

* * *

10.

Defendant-appellant files herewith in connection with this application for a new hearing, a brief in support thereof and shows that for the reasons hereinabove stated and enlarged in the said brief a rehearing should be granted.

WHEREFORE, the premises considered, defendant-appellant prays that a rehearing be granted in this appeal and that after due proceedings had the judgment and opinion rendered herein on the 26th day of September, 1995, be set aside and reversed and that there be judgment entered herein in favor of your defendant-appellant dismissing plaintiffs-appellees demands at their cost and to their prejudice.

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IT IS HEREBY CERTIFIED that a copy of the foregoing Application by Defendant-Appellant for Rehearing has been served on Marion F. Edwards, Esquire, Post Office Box 81, Gretna, Louisiana, 70054, and David Charles Loeb, Esquire, 3445 North Causeway Boulevard, Suite 103, Metairie, Louisiana, 70002, by hand, facsimile, or by U.S. Mail, postage prepaid and properly addressed this 10TH day of October, 1995.

s/Sylvan J. Steinberg
SYLVAN J. STEINBERG

COURT OF APPEAL

FIFTH CIRCUIT

STATE OF LOUISIANA

DOCKET NO. 94-CA-306

JANETTE M. wife of/and CHARLIE KORNMAN,
Individually
and on behalf of their dependent son,
RICHARD JAY KORNMAN

Plaintiffs-Appellees

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

Defendant-Appellant

Appeal from the Twenty-Fourth Judicial District
Court, Parish of Jefferson, State of Louisiana,
Docket No. 364,688, Div. "E",
the Honorable Clarence E. McManus, Presiding

BRIEF IN SUPPORT OF APPLICATION BY DEFENDANT-APPELLANT LOUISIANA HEALTH SERVICE AND INDEMNITY COMPANY (BLUE CROSS/BLUE SHIELD OF LOUISIANA) FOR REHEARING

Respectfully submitted

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MAY IT PLEASE THE COURT:

I. THE MEDICAL EXPENSE PLAN ESTABLISHED BY COAST QUALITY CONSTRUCTION CO. FOR ITS EMPLOYEES IS AN ERISA PLAN

The Medical Expense Plan (MEP) established by Coast Quality Construction Company (Coast) for its employees, one of which was Charlie Kornman, is a Medical Expense Plan as defined by the Employee Retirement Income Security Act (ERISA). This Honorable Court erred in holding that the Coast MEP is not an ERISA plan. In so holding this Court is in conflict with the Court of Appeal, First Circuit, State of Louisiana in the case of Cramer v. Association Life Insurance Company, 563 So.2d 267 (La.App. 1st Cir. 1990). In the Cramer case the First

Circuit Court of Appeal found the facts to be:

> *The record shows that Mr. Cramer's employer, ABC, through its president, Charles Cramer, Sr., made an application for group life, health, and medical insurance with ALIC. The group insurance application by ABC was approved by ALIC and became effective on August 1, 1985. Charles Cramer, Jr., an employee of ABC, together with his wife and minor daughter were covered under the group policy, as were other employees of ABC, their spouses, and their dependents. According to ABC's application, ABC contributed 50% of the cost of the employee benefits.*
>
> *Under the factors set forth in Donovan, we find that ABC established an employee benefit plan for the purpose of purchasing insurance. The extended benefits were provided to the employees of ABC, their spouses, and their dependents. Fifty percent of the insurance premiums were paid by ABC, and ABC, not the individual employees, maintained the plan.*
>
> *Accordingly, we find that the ABC plan is an employee welfare benefit plan within the contemplation of ERISA and that the trial court erred in finding to the contrary.* See *Cramer v. Association Life Insurance Co.*, 563 So.2d 267, at p. 272 (La. App. 1st Cir. 1990).

The facts in the Cramer case are very similar, if not the same as those in the instant case. ABC, as did Coast, made an application of medical insurance to cover its medical expense plan for its employees. The employees of ABC were covered under the insurance as were the employees of Coast. ABC, as did Coast, contributed to the cost of premiums, and ABC, as did Coast, paid the balance of premiums to maintain the insurance

and plan. Accordingly, the ABC plan as found by the First Circuit Court of Appeal was an ERISA plan just as this Court should find the Coast MEP an ERISA plan. The First Circuit Court of Appeal did not ignore Taggart Corp. v. Life and Health Benefits Administration, 617 F.2d 1208 (5th Cir. 1980) cert. denied 450 U.S. 1030 (1981). Taggart was not applicable because the facts in Taggart were entirely different from the facts in the Cramer case relative to the medical expense plan provided by the employer. The facts in this case are also entirely different from the facts in Taggart.

(1) Unlike the Taggart case where there was only one employee, Charlie Kornman was not the only employee of Coast and not the only employee of Coast enrolled in the medical expense as was the case in Taggart;

(2) Unlike the Taggart case, this case does not involve the bare purchase of insurance. Coast was much more involved with the medical expense plan as follows:

(3) Coast chose to provide health benefits for its employees and arranged for the plan;

(4) Coast chose the coverage the plan would provide to its employees;

(5) Coast paid a percentage of each employee's premium;

(6) Coast deducted the remaining percentage from each employee's paycheck through payroll deductions;

(7) Coast controlled and administered all funds deducted from employee's paychecks;

(8) Coast assumed responsibility for submitting the premium payments to Blue Cross each month;

(9) Coast assumed responsibility for the balance of premiums.

All of this evidence and these facts were brought out during the trial of this matter in the 24th Judicial District Court. See, Testimony of D. Epstein, Tr. at pp. 987-89, Testimony of M. Echlin, Tr. at p. 1730.

As pointed out above the facts in the Cramer case are very similar, if not the same as those in this case. Thus, the argument that the Taggart case should be followed by this Court to find the Coast MEP is not an ERISA plan is not well founded. Taggart is only applicable to cases with similar fact situations. This case with the Kornmans and the Coast MEP is not such a case. Clearly, the facts in the instant case are directly at odds with the facts in the Taggart case.

In holding that the Coast MEP is not an ERISA plan this Court is also in conflict with the Court of Appeal, Third Circuit, State of Louisiana in the case of West, Jr. v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La. App. 3rd Cir. 1991). In that case in a footnote at page 1297 the Third Circuit held:

> 1. Although it is unclear whether West also contends that the disability policy issued by Connecticut is not an ERISA-type plan and not subject to ERISA, we have considered that contention nonetheless and conclude that the Con-

> necticut policy is an ERISA-type plan. The record shows that the plan is offered only to employees of the employer, Raymond International, is co-sponsored and maintained by Raymond International and includes specific references to ERISA in the summary plan description of the disability policy. These factors make it clear that the disability policy is an ERISA-type plan. 29 U.S.C. § 1002; *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988); cert. denied, 492 U.S. 906, 109 S.Ct. 3216, 106 L.Ed. 566 (1989).

As in the West case Coast offered the plan to employees of Coast, the employer. Also ERISA is specifically referred to in the Coast MEP. See Plan Summary for 1984, Plaintiffs Exhibit 3 p. 15, Employee Booklet; Plan Summary for 1985, Plaintiffs Exhibit 4, p. 26, Employee Booklet, Plan Summary for 1987, Plaintiffs Exhibit 6, p. 15, Employee Booklet.

Furthermore, this Court is in error in its finding that there was no trust for ERISA to protect. The MEP established by Coast for its employees had assets to protect and those assets should be protected by ERISA. Coast and the MEP had a fiduciary relationship with its employees who were participants in and members of the MEP, and Coast had a trust of their funds. Coast deducted for the MEP a percentage from each employees pay check through payroll deductions to pay for each employees premium due for participation in the MEP. Coast itself paid the remaining percentage due for each employees premium. Coast controlled and administered for the MEP all funds deducted from employees' pay checks and controlled and administered its own funds to pay premiums. Coast assumed responsibility for the

MEP for submitting the premium payments to Blue Cross each month. Coast assumed responsibility for the balance of the premiums due by the MEP. Coast thus established a trust of employee funds and Coast funds to pay premiums due by the MEP. The MEP and Coast had a trust and fiduciary responsibility to Coast employees and the MEP established by Coast for its employees that ERISA is intended and meant to protect and should protect.

ERISA applies to both self-insured as well as insured medical expense plans. Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed. 2d 728 (1985); Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 107 St.Ct. 1549, 95 L.Ed. 39, 50-51 (1987). What more control, administration and responsibility could any employer have with an MEP than what Coast had? It controlled what insurance was purchased, what coverages were provided, what percentage of premiums each employee paid, administered how the premiums are paid, assumed responsibility for payment of premiums. If this is not enough involvement of an employer in an MEP then the implication of this Courts' holding is that an insured MEP is not an ERISA plan. The Coast MEP did not simply purchase insurance. It controlled, administered and assumed responsibility for the MEP. This is not the "bare purchase of health insurance."

The Coast MEP for its employees is an ERISA plan and this Court should have considered whether the Coast MEP is an indispensable party, whether plaintiffs-appellees suit is premature for failure to exhaust administrative remedies and whether the state law relied on by plaintiffs-appellees is preempted by ERISA.

* * *

CONCLUSION

Considering the arguments made in defendant-appellant's Application for Rehearing and this Brief in Support of the Application for Rehearing this Honorable Court should grant a rehearing in this matter and after due proceedings the judgment and opinion rendered by this Honorable Court on September 26, 1995, should be set aside and reversed and judgment entered herein in favor of your defendant-appellant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana), dismissing plaintiffs-appellees demand, at their costs and to their prejudice.

Respectfully submitted:

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CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that a copy of the foregoing Brief in Support of Application by Defendant-Appellant Louisiana Health Service and Indemnity Company (Blue Cross/ Blue Shield of Louisiana) for Rehearing has been served on

Marion F. Edwards, Esquire, Post Office Box 81, Gretna, Louisiana, 70054, and David Charles Loeb, Esquire, 3445 North Causeway Boulevard, Suite 103, Metairie, Louisiana, 70002, by hand, facsimile, or by U.S. Mail, postage prepaid and properly addressed this 10th day of October, 1995.

s/Sylvan J. Steinberg

SYLVAN J. STEINBERG

APPENDIX H

24TH JUDICIAL DISTRICT COURT FOR THE
PARISH OF JEFFERSON

STATE OF LOUISIANA

NO. 364-688 DIVISION "E"

JANETTE M., WIFE OF/AND CHARLIE KORNMAN,
INDIVIDUALLY AND ON BEHALF OF THEIR
DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

FILED:_____ _____
DEPUTY CLERK

EXCEPTIONS

NOW INTO COURT, through undersigned counsel, comes defendant Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana), appearing herein solely for the purposes of these exceptions, and excepts to the plaintiffs' Petition and Amended Petition on the following grounds:

1.

The said Petition and Amended Petition disclose no cause or right of action for the reasons more particularly set forth

in the Memorandum attached hereto and made a part hereof.

2.

Janette and Charlie Kornman lack procedural capacity to bring suit for the reasons more particularly set forth in the Memorandum attached hereto and made a part hereof.

3.

There is a nonjoinder of a necessary party defendant herein for the reasons more particularly set for in the Memorandum attached hereto and made a part hereof.

4.

Plaintiffs' plea is premature in that plaintiffs have failed to exhaust their administrative remedies for the reasons more particularly set forth in the Memorandum attached hereto and made a part hereof.

5.

This Honorable Court is without jurisdiction over the subject matter of the above-captioned matter for the reasons more particularly set forth in the Memorandum attached hereto and made a part hereof.

WHEREFORE, exceptor prays that the above exceptions, as more fully set forth in the attached Memorandum incorporated by reference herein, be maintained and that the suit be dismissed at plaintiffs' costs.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing document has been served on all counsel of record by hand or by placing same in the United States Mail, postage prepaid and properly addressed, this __ day of January, 1989.

s/Sylvan J. Steinberg

24TH JUDICIAL DISTRICT COURT FOR THE
PARISH OF JEFFERSON

STATE OF LOUISIANA

NO. 364-688 DIVISION "E"

JANETTE M., WIFE OF/AND CHARLIE KORNMAN,
INDIVIDUALLY AND ON BEHALF OF THEIR
DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

FILED: _____ _____
DEPUTY CLERK

MEMORANDUM IN SUPPORT OF EXCEPTIONS

NOW INTO COURT, through undersigned counsel, comes Louisiana Health Service and Indemnity Company (Blue Cross and Blue Shield of Louisiana) (hereinafter referred to as "Blue Cross"), and respectfully submits this Memorandum in support of the Exceptions filed by Blue Cross in the above-captioned suit.

I.

FACTS

* * *

II.

PEREMPTORY EXCEPTIONS

A. NO RIGHT AND/OR CAUSE OF ACTION

* * *

Further, none of the plaintiffs have stated a valid cause of action because the causes of action alleged in the plaintiffs' suit have been preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, et seq. What Coast has offered its employees is an ERISA plan. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982); Dependahl v. Falstaff Brewing Corp., 491 F.Supp. 1188 (E.D. Mo. 1980), mod. on other grounds, 653 F.2d 1208 (8th Cir.), cert. denied, 454 U.S. 968 (1981); Scott v. Gulf Oil Corp., 754 F.2d 1499 (9th Cir. 1985); Credit Manager's Association v. Kennesaw Life and Accident Insurance Co., 809 F.2d 617 (9th Cir. 1987); Bausch and Lomb, Inc. v. Smith, 630 F.Supp. 262 (W.D.N.Y. 1986); Benvenuto v. Connecticut General Insurance, 643 F.Supp. 87 (D.N.J. 1986).

ERISA preempts any state law that "relates to" an ERISA plan. 29 U.S.C. §1144(a); see also Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549; 95 L.Ed.2d 39 (1987). Although ERISA's preemption provision contains a "savings clause", 29 U.S.C. §1144(b)(2)(a), state law penalty statutes such as Louisiana R.S. 22:657, which is raised by plaintiffs, are not saved from preemption by that section. Taylor v. Blue Cross/ Blue Shield of New York, 684 F.Supp. 1352, 1356 (E.D. La. 1988); Rasmussen v. Metropolitan Life Insurance Co., 675 F.Supp. 1497, 1503 (W.D. La. 1987). See also Locklear v. Visko's, So.2d 933 (La. App. 5th Cir. 1988) (La. R.S. 22:213 and 22:636 are preempted by ERISA).

In addition to the preemptive action of 29 U.S.C. § 1144, the Supreme Court has held that ERISA's civil enforcement provision, 29 U.S.C. §1132, preempts all other causes of action concerning a claim for benefits by a member or beneficiary of the ERISA plan. Dedeaux, 95 L.Ed.2d at 52; Varhola v. Doe, 820 F.2d 809, 817 (6th Cir. 1987); Roberson v. The Equitable Life Assurance Society of the United States, 661 F.Supp. 416, 424 (C.D. Cal. 1987); Smith v. Electronics Data Systems Corp., 657 F.Supp. 1242, 1243 (D. Colo. 1987); Taylor, 684 F.Supp. at 1358. ERISA does not provide a claim for punitive damages. 29 U.S.C. §1132; see Sommer's Drug Stores v. Corrigan Enterprises, Inc., 793 F.2d 1456, 1464-65 (5th Cir. 1986), cert. denied, 107 S.Ct. 884 and 107 S.Ct. 1298 (1987); Varhola v. Doe, 820 F.2d at 817; Kleinhaus v. Lisle Savings Profit Sharing Trust, 810 F.2d 617 (7th Cir. 1987); Powell v. Chesapeake and Potomac Telephone Co., 780 F.2d 419, 424 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986); Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208, 1216 (8th Cir.), cert. denied, 454 U.S. 968 (1981). As the Supreme Court reasoned in Dedeaux:

> [T]he detailed provisions of [§1132(a)] set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plan. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in [§1132(a)] of the statute provide strong evidence that Congress did not intend to authorize other

remedies that it simply forgot to incorporate directly."

Dedeaux, 95 L.Ed.2d at 52, quoting Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 146 (1985).

Louisiana R.S. 22:657 clearly provides a remedy not granted by ERISA and is thus preempted under 29 U.S.C. §1132.

III.

DILATORY EXCEPTIONS

* * *

B. NONJOINDER OF A NECESSARY PARTY

As was discussed above, the Coast Quality Construction Company Group Medical Contract constitutes an ERISA plan under 29 U.S.C. §1001, et seq. The Plan is established by Coast Quality Construction Company for the benefit of its employees. In suits under ERISA, the Plan must be joined as a party, since the Plan ultimately is liable for all payments. Coast should be joined as a necessary party to the suit as the Plan's representative.

C. PREMATURITY

The instant law suit was prematurely filed. Pursuant to the terms of the ERISA Plan, as set forth in the Plan Summary, (Exhibit D, p. 15; Exhibit E, p. 26; Exhibit F, p. 15), if the plaintiffs believe their claims were improperly denied, they should have filed an appeal with the ERISA review department of Blue Cross and Blue Shield of Louisiana within sixty (60) days after the Plan mailed a written notice of denial of the claim. The plaintiffs have failed to file such an appeal. The suit is therefor premature until the plaintiffs exhaust their administrative rem-

edies under the ERISA Plan. "It is well established that the failure to pursue and exhaust administrative remedies precludes judicial relief." Taylor v. South Central Bell, 422 So.2d 528, 529 (La. App. 5th Cir. 1982), citing Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980) and Steeg v. Lawyer's Title Insurance Corporation, 329 So.2d 719 (La. 1976); see also Zipf v. American Telephone and Telegraph Co., 799 F.2d 889, 892 (3rd. Cir. 1986).

Further, plaintiffs have made claims for "future medical expenses." Such medical expenses do not currently exist, and such expenses would not automatically be payable by Blue Cross, even if plaintiffs were successful on their other claims raised in the Petition and Amended Petition. Future claims would have to meet the other requirements of the Contract. A determination of whether those claims meet the Contract's requirements must be made by Blue Cross as Claims Administrator. Denton v. First National Bank of Waco, Texas, 765 F.2d 1295, 1304 (5th Cir. 1983); Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985); In Berry, the court noted that administrative responsibility rests with those whose experience is daily and continual, and not with judges whose exposure is episodic and occasional. Berry, 761 F.2d at 1006.

IV.

DECLINATORY EXCEPTION

A. LACK OF SUBJECT MATTER JURISDICTION

This case is a claim for benefits under an ERISA Plan. The federal courts have original jurisdiction over suits involving claims for benefits under ERISA. 29 U.S.C. §1132(f). Pursuant to 28 U.S.C. §1441(a), Blue Cross properly and timely removed the suit to the United States District Court for the Eastern District

of Louisiana. The federal district court improperly remanded the case under 28 U.S.C. §1447(c) which order was not reviewable, by appeal or otherwise, by the United States Court of Appeals of the Fifth Circuit. 28 U.S.C. §1447(d). This court lacks subject matter jurisdiction because the case properly removed by defendant and defendant is entitled to a federal forum pursuant to 28 U.S.C. §1441(a). Once this case left this court and was properly removed to the federal district court, the state court lost subject matter jurisdiction over the case. A federal court with jurisdiction over the case may not choose in its discretion to remand the case to state court. Since the federal district court had jurisdiction over the plaintiffs' ERISA claims the court's remand of the case was improper and this court does not have jurisdiction over the case.

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ATTORNEYS FOR LOUISIANA HEALTH SERVICE AND INDEMNITY COMPANY (BLUE CROSS AND BLUE SHIELD OF LOUISIANA)

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing document has been served on all counsel of record by hand or by placing same in the United States Mail, postage prepaid and properly addressed, this __ day of January, 1989.

s/Sylvan J. Steinberg

APPENDIX I

CLAIMS REVIEW AND APPEALS

If your claim is denied in whole or in part, Blue Cross and Blue Shield of Louisiana will explain within a reasonable time in writing why benefits were denied. If you believe that a claim has been incorrectly denied and you want to appeal the denial of benefits, you will receive a full and fair review. If you, or your legal representative, want to appeal the denial of benefits, you must notify Blue Cross and Blue Shield of Louisiana, ERISA Review Department (Customer Service Center), P. O. Box 15699, Baton Rouge, LA 70895. After appeal notice has been received, you or your duly authorized representative may, upon written request, review pertinent non-confidential documents relating to the claim's denial and you may submit issues and comments in writing. In your request for a review, please state the reason you think your claims should not have been denied and include any other documents, dates, information or comments that you feel have a bearing on the claim. You must file an appeal as mentioned in this section within 60 days after the Plan has mailed you written notice of denial of your claim to your last known address. A decision on your claims appeal will be made promptly and no later than 60 days after receipt of your appeal notice. In unusual cases, such as those which require review of technical records by medical specialists, the review may take longer than 60 days. The decision on your appeal will include specific reasons for the decision with specific references to the Plan's provision on which the decision is based.

APPENDIX J

RULE IX. REHEARINGS

. . .

Section 6. An application for rehearing will not be considered when the court has merely granted or denied an application for a writ of certiorari or a remedial or other supervisory writ, or when the judgment of this court is merely overruling a motion to dismiss an appeal or a motion to recall or rescind a rule nisi, or when, for any reason, the judgment has not finally disposed of the case in this court, or when an election case has been decided as provided by Rule X, Section 5(c).

APPENDIX K

SUPREME COURT OF LOUISIANA

NO. 95 C 3025

JANETTE M. wife of/and CHARLIE KORNMAN, INDIVIDUALLY AND ON BEHALF OF THEIR DEPENDENT SON, RICHARD JAY KORNMAN

VERSUS

BLUE CROSS/BLUE SHIELD OF LOUISIANA

ON APPLICATION FOR WRIT OF CERTIORARI, REMEDIALWRIT OR WRIT OF REVIEW OF THE JUDGMENT OF THE COURT OF APPEAL, FIFTH CIRCUIT, STATE OF LOUISIANA IN NO. 94-CA-306

ORIGINAL APPLICATION FOR WRIT OF CERTIORARI, REMEDIAL WRIT OR WRIT OF REVIEW ON BEHALF OF LOUISIANA HEALTH SERVICE AND INDEMNITY COMPANY (BLUE CROSS/BLUE SHIELD OF LOUISIANA)

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* * *

STATEMENT OF REASONS FOR GRANTING WRIT UNDER RULE X, SECTION 1 (a)

1. The decision of the Court of Appeal, Fifth Circuit, conflicts with decisions of the Court of Appeal, First Circuit, State of Louisiana, and the Court of Appeal, Third Circuit, State of Louisiana, in the cases of Cramer v. Association Life Insurance Company, 563 So.2d 267 (La. App. 1st Cir. 1990) and West v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La. App. 3rd Cir. 1991) as to whether an employer established medical expense plan for employees is an ERISA (Employee Retirement Income Security Act) plan. [The Supreme Court of Louisiana did not reverse the First Circuit finding and holding in Cramer, supra that the medical expense plan established by an employer for its employees was a medical expense plan as defined by the Employee Retirement Income Security Act (ERISA). Cramer v. Association Life Insurance Company, 569 So.2d 533 (La. 1990), cert. denied, 499 U.S. 938 (1991).]

The decision of the Court of Appeal, Fifth Circuit, State of Louisiana, also conflicts with decisions of the United States Court of Appeal, Fifth Circuit, in the cases of Memorial Hospital Sys. v. Northbrook Life Ins. Co., 904 F2d 236 (5th Cir. 1990) and Rodriguez v. Pacificare of Texas, Inc., 980 F2d 1014 (5th Cir. 1993). It is submitted that writs should be granted to secure uniformity of jurisprudence.

2. The Court of Appeal, Fifth Circuit, has decided significant questions and issues of law, which have not been, but should be, resolved by this Court. The Court of Appeal, Fifth Circuit, has, in error, interpreted and decided as a matter of law that a medical expense plan established by an employer for its employ-

ees is not an ERISA plan. The Court of Appeal, Fifth Circuit, has, in error, interpreted and decided as a matter of law that La. R.S. 22:215 A(1)(a) precludes a group health insurer from requiring a dependent of an individual employee to complete an application form and questionnaire and answer health questions before being insured. Further, the Court of Appeal, Fifth Circuit, has, in error, decided as a matter of law, what is meant by the term "self-support". The decisions of the Court of Appeal, Fifth Circuit, State of Louisiana, in these respects will have widespread impact on the health insurance industry and on participants and beneficiaries of employer established medical expense plans for employees.

3. The Court of Appeal, Fifth Circuit, has erroneously applied and interpreted the law as set forth in the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001, et seq.; LA. R.S. 22:215 A(1)(a), LA. R.S. 22:657, the term "self-support", and the word "Individual" as used in La.R.S. 22:215 A(1)(a), all of which will cause confusion, material injustice and significantly affect the public interest.

* * *

ASSIGNMENT OF ERRORS

1. The Court of Appeal, Fifth Circuit, erred in holding that the medical expense plan ("Coast MEP") established by the employer, Coast Quality Construction Company ("Coast") for its employees was not an employee medical expense plan as defined by the Employee Retirement Income Security Act (ERISA).

2. The Court of Appeal, Fifth Circuit, erred in not addressing or considering the other ERISA issues in this matter including the preemption by ERISA of the state law claims made by the

plaintiffs, whether the Coast MEP is an indispensable party in this suit, whether the plaintiffs' suit is premature for failure to exhaust administrative remedies.

* * *

SUMMARY OF ARGUMENT

1.

Coast Quality Construction Company ("Coast") established a medical expense plan ("Coast MEP") for all of its employees. Coast determined that it would get Louisiana Health Service and Indemnity Co. (Blue Cross/Blue Shield of Louisiana) ("Blue Cross") to insure the Coast MEP. Charlie Kornman, who was only one of the many Coast employees, became a participant in the Coast MEP with the other employees. Initially, Charlie Kornman did not attempt to enroll Richard Kornman in the Coast MEP as his dependent. However, later he attempted to enroll and qualify Richard Kornman as his dependent under the plan. He did so my completing and signing a Group Change of Status form ("application") that contained questions relative to Richard's health. See Appendix Exhibit G.

The medical expense plan established by Coast for its employees ("Coast MEP") is an "employee welfare benefit plan" as defined by the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §1002(1). Coast owned, controlled, administered and/or assumed responsibility for the Coast MEP and the Blue Cross policy that insured it. Among other things, Coast chose to provide health benefits for its employees and arranged for the plan, Coast chose the medical coverage the plan would provide to its employees and what coverages the Blue Cross policy, which insured the Coast MEP, would provide. Coast paid a percentage of each employee's premium due Blue Cross, Coast

deducted the remaining percentage due for premium from each employees' pay check through payroll deductions, Coast controlled and administered all funds deducted from employees' pay checks, Coast assumed responsibility for submitting the premium payments to Blue Cross each month and Coast assumed responsibility for the balance of any premiums due. Plaintiffs do not dispute any of these facts.

The Coast MEP for its employees clearly qualifies as an ERISA plan under 29 U.S.C. §1002(1) since it was a program established by Coast for the purpose of providing medical, surgical or hospital benefits in the event of sickness or accident to the employees of Coast. Additionally, the Coast MEP is an ERISA plan in light of recent decisions by the Court of Appeal, First Circuit, State of Louisiana, in the case of Cramer v. Association Life Insurance Company, 563 So.2d 267 (La. App. 1st Cir. 1990) and by the Court of Appeal, Third Circuit, in the case of West v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La. App. 3rd Cir. 1991). In holding that the MEP established by Coast for its employees is not an employee medical expense plan as defined by ERISA the Court of Appeal, Fifth Circuit, is in conflict with these cases decided by the Courts of Appeal in the First and Third Circuits. In addition, in so holding, the Court of Appeal, Fifth Circuit, is in conflict with recent decisions by the United States Court of Appeal, Fifth Circuit in the cases of Memorial Hospital Systems v. Northbrook Life Insurance Co., 904 F2d 236, 242-43 (5th Cir. 1990); and Rodriguez v. Pacificare of Texas, Inc., 980 F2d 1014, 1016-17, N.2 (5th Cir. 1993). This conflict between the Court of Appeal, Fifth Circuit, State of Louisiana, in this matter and the Courts of Appeal, First Circuit and Third Circuit, State of Louisiana in the Cramer case, supra and West case, supra will cause great confusion as to whether a medical expense plan established by an employer for its employees is an ERISA plan. Furthermore, the conflict between the Court of Appeal, Fifth Circuit, State of

Louisiana, and the United States Court of Appeal, Fifth Circuit will cause even greater confusion. Medical expense plans established by employers for their employees with the same set of facts as this case, the Kornman case, litigated in the federal courts will be held to be ERISA medical expense plans. Whereas, medical expense plans established by employers for their employees with the same facts as in this case, the Kornman case, litigated in Louisiana courts will be held not to be ERISA medical expense plans. Employers, as well as employees in this State will not know whether they have or are participants in ERISA medical expense plans. There will not be uniformity of jurisprudence.

It is counsel's understanding that the United States Department of Labor will not join in a writ application to any court unless asked to do so by the court in question. However, it is counsel's further understanding that the position of the United States Department of Labor on the issue of whether ERISA would apply in a fact situation as found in this case, the Kornman case, would be opposite to the holding and decision of the State of Louisiana, Court of Appeal for the Fifth Circuit, i.e., the United States Department of Labor would take the position that the Coast MEP was an ERISA plan.

2.

As submitted and argued in this Application for Writs, the Coast MEP for its employees is an ERISA medical expense plan. Since ERISA is applicable state law claims and other claims made by plaintiffs in these proceedings based on the Louisiana Revised Statutes are preempted by ERISA including plaintiffs' claims for penalties and attorneys' fees pursuant to La. R.S. 22:657. 29 U.S.C. §1132. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.RD. 2d 39, 51 (1987); Cramer v. Association Life Insurance Co., 569 So.2d 533

(LA 1990), cert. denied 499 U.S. 938 (1991); Tingle v. Pacific Mutual Insurance Co., 996 F 2d 105, 109-110 (5th Cir. 1993); West v. Connecticut General Life Insurance Co., 591 So.2d 1296 (La. App. 3rd Cir. 1991); Taylor v. Blue Cross/Blue Shield of New York, 684 F. Supp. 1352, 1317-59 (E. D. La. 1988). Further, since the Coast MEP was an ERISA plan, the plan itself is an indispensable party in this matter. 29 U.S.C. §1132. In addition, since the plaintiffs are seeking to recover benefits allegedly due to them under an ERISA plan, the proper defendant is the plan (in this case the Coast MEP) which must be sued as an independent entity pursuant to 29 U.S.C. §1132(d)(1). Further, the plaintiffs suit is premature. Pursuant to the terms of the Coast MEP if the plaintiffs' believed that their claim was improperly denied they should have filed an appeal with the ERISA Review Department of Blue Cross. Plaintiffs never filed an appeal. Therefore, this suit is premature. Rodriguez v. Pacificare of Texas, Inc., 980 F2d 1014, 1016-17 (5th Cir. 1990); Denton v. First National Bank, 765 F2d 1295, 1300-03 (5th Cir. 1985); Taylor v. South Central Bell, 422 So.2d 528, 29 (La. App. 5th Cir. 1980), citing Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980).

* * *

ARGUMENT

I. THE MEDICAL EXPENSE PLAN UNDER WHICH, PLAINTIFFS, THE KORNMANS, CLAIM ENTITLEMENT TO BENEFITS IS AN ERISA PLAN

Coast established a medical expense plan insured by Blue Cross for its employees. ("Coast MEP") Coast arranged for the plan, chose the coverage the plan would provide to its employees, chose to insure the plan, selected Blue Cross to insure the plan. Further, Coast paid a percentage of each employee's premium and deducted the remaining percentage from each employee's paycheck through payroll deductions. Additionally,

Coast controlled and administered all funds deducted from employee's paychecks, assumed responsibility for any balance due Blue Cross for premiums and administered all funds deducted from employees' paychecks. All of this evidence and these facts were brought out at the trial of this matter. Testimony of D. Epstein, an executive of the employer, Coast Quality Construction Company, Tr. at pp. 987-89, Testimony of M. Echlin, Tr. at p. 1730. Charlie Kornman, an employee of Coast, enrolled himself in the Coast MEP as an employee of Coast and enrolled his wife in the Coast MEP as his dependent. Blue Cross Exhibit "2" in the record. Initially Charlie Kornman did not attempt to enroll Richard Kornman as a dependent. Testimony of J. Kornman, Transcript at pp. 1982-83; Testimony of D. Epstein, Transcript at pp. 942-944, 1014. Later he attempted to qualify Richard Kornman as his dependent in the Coast MEP. Blue Cross Exhibit "3" in the record. See Appendix Exhibit G.

The medical expense plan established by Coast for its employees ("Coast MEP") under which plaintiffs claim they are entitled to benefits is, in reality, an "employee welfare benefit plan" as defined by the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §1002(1). An ERISA plan is defined as:

> any plan, fund or program . . . established by an employer or employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of the insurance or otherwise, (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

See, 29 U.S.C. §1002(1). The Coast MEP clearly qualifies as an ERISA plan under the language of the statute, because it is a

program established by Coast for the purpose of providing medical, surgical or hospital benefits in the event of sickness or accident to the employees of Coast. Additionally, the Coast plan qualifies as an ERISA plan pursuant to the decision of the Court of Appeal, First Circuit, State of Louisiana, in the case of Cramer v. Association Life Insurance Co., 563 So.2d 267 (La. App. 1st Cir. 1990). In the Cramer case, the Court of Appeal, First Circuit, found the facts to be:

> *The record shows that Mr. Cramer's employer, ABC, through its president, Charles Cramer, Sr., made an application for group life, health, and medical insurance with ALIC. The group insurance application by ABC was approved by ALIC and became effective on August 1, 1985. Charles Cramer, Jr., an employee of ABC, together with his wife and minor daughter were covered under the group policy, as were other employees of ABC, their spouses, and their dependents. According to ABC's application, ABC contributed 50% of the cost of the employee benefits.*
>
> *Under the factors set forth in Donovan, we find that ABC established an employee benefit plan for the purpose of purchasing insurance. The extended benefits were provided to the employees of ABC, their spouses, and their dependents. Fifty percent of the insurance premiums were paid by ABC, and ABC, not the individual employees, maintained the plan.*
>
> *Accordingly, we find that the ABC plan is an employee welfare benefit plan within the contemplation of ERISA and that the trial court erred*

> *in finding to the contrary.* See Cramer v. Association Life Insurance Co., 563 So.2d 267, at p. 272 (La. App. 1st Cir. 1990).

See also Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

The facts in the Cramer case are very similar, if not the same as those in the instant case. ABC, as did Coast, made an application for medical insurance to cover its medical expense plan for its employees. The employees of ABC were covered under the insurance as were the employees of Coast. ABC, as did Coast, contributed to the cost of premiums, and ABC, as did Coast, paid the balance of premiums to maintain the insurance and plan. Accordingly, the ABC plan, as found by the Court of Appeal, First Circuit, was an ERISA plan just as the Coast MEP should be found to be an ERISA plan. Further, the Coast MEP is an ERISA plan pursuant to the decision of the Court of Appeal, Third Circuit, State of Louisiana, in the case of West v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La. App. 3rd Cir. 1991).

Additionally, the Coast MEP qualifies as an ERISA plan in light of recent decisions by the United States Court of Appeal, Fifth Circuit as to what constitutes an ERISA plan.

The United States Court of Appeal, Fifth Circuit, has found that the employer's involvement in the plan determines whether a plan meets the requirements to establish an ERISA welfare benefit plan. See, Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 242-43 (5th Cir. 1990); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016-17, n.2 (5th Cir. 1993).

In Rodriguez, the employees contributed, through pay-

roll deductions, a portion of the insurance premiums; the employer paid the balance. The Fifth Circuit specifically held in Rodriguez that such an arrangement and involvement by the employer established an ERISA plan. Rodriguez, 980 F.2d at 1017, n.2. Likewise, a similar arrangement by the employer was found sufficient in the Memorial Hospital case to establish an ERISA plan. Memorial Hospital, 904 F.2d at 242-43.

The Coast plan is exactly the same situation that occurred in Rodriguez and Memorial Hospital. The Coast employees contributed, through payroll deductions, a portion of the insurance premiums; Coast paid the balance. Testimony of D. Epstein, an executive of Coast, Transcript at pp. 987-89. The U.S. Fifth Circuit has specifically held that such a plan qualifies as an ERISA medical expense plan. The trial court and Court of Appeal, Fifth Circuit, were therefore, incorrect in holding that the Coast MEP for its employees was not an ERISA plan.

The trial court and the Court of Appeal, Fifth Circuit, rely on the case of Taggart Corp. v. Life & Health Benefits Administration, Inc., 617 F.2d 1208 (5th Cir. 1980), cert. denied 450 U.S. 1030 (1981) in holding that the Coast MEP in this case does not qualify as an ERISA plan. Taggart is not the United States Court of Appeal, Fifth Circuit, seminal decision on this issue. Taggart is an early Fifth Circuit decision which has since been qualified in more recent U.S. Fifth Circuit decisions. See Rodriguez, 980 F.2d 1014 (5th Cir. 1990) and Memorial Hosp., 904 F.2d 236 (5th Cir. 1990).

The U. S. Fifth Circuit in Memorial Hospital, specifically distinguished Taggart from a situation involving similar facts to those at issue in this case. Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 242-43 (5th Cir. 1990).

(1) Unlike the Taggart case where there was only one employee, Charlie Kornman was not the only employee of Coast and not the only employee of Coast enrolled in the medical expense plan as was the case in Taggart. Coast had a large number, if not all, of its other employees in addition to Charlie Kornman enrolled in its medical expense plan;

(2) Unlike the Taggart case, this case does not involve the bare purchase of insurance. Coast, and not a trust entity as in Taggart, was much more involved with the medical expense plan as follows:

(3) Coast chose to provide health benefits for its employees and arranged for the plan;

(4) Coast chose the coverage the plan and its insurer would provide to its employees;

(5) Coast paid a percentage of each employee's premium;

(6) Coast deducted the remaining percentage from each employee's paycheck through payroll deductions;

(7) Coast controlled and administered all funds deducted from employee's paychecks;

(8) Coast assumed responsibility for submitting the premium payments to Blue Cross each month.

All of this evidence and these facts were brought out

during the trial of this matter in the 24th Judicial District Court. Testimony of D. Epstein, an executive of Coast, Tr. at pp. 987-89, Testimony of M. Echlin, Tr. at p. 1730.

The U. S. Fifth Circuit has found that such an arrangement sufficiently establishes the necessary employer relationship needed to constitute an ERISA plan. Memorial Hosp. Sys. v. Northbrook Life Ins. Co., supra., Rodriguez v. Pacificare of Texas, Inc., supra. The State of Louisiana, Courts of Appeal for the First and Third Circuits have also found that with this employer involvement an ERISA plan is established. Cramer v. Association Life Insurance Company, 563 So.2d 267 (La. App. 1st Cir. 1990) and West v. Connecticut General Life Insurance Co., 591 So.2d 1296 (La. App. 3rd Cir. 1991).

Thus, it is submitted that the decision by the trial court and Court of Appeal, Fifth Circuit, that the Taggart case should be followed to find the Coast MEP is not an ERISA plan is in error. Taggart is only applicable to cases with similar fact situations. This case with the Kornmans and the Coast MEP is not such a case. Clearly, the facts in the instant case are directly at odds with the facts in the Taggart case.

As previously set forth herein in the Statement of Reasons for Writ under Rule X, Section 1(a) and Summary of the Argument, the decision of the trial court and Court of Appeal, Fifth Circuit, conflicts with decisions of the Court of Appeal, First Circuit, State of Louisiana, and the Court of Appeal, Third Circuit, State of Louisiana, in the cases of Cramer v. Association Life Insurance Company, 563 So.2d 267 (La. App. 1st Cir. 1990) and West v. Connecticut General Life Insurance Company, 591 So.2d 1296 (La. App. 3rd Cir. 1991) as to whether an employer established medical expense plan for employees is an ERISA (Employee Retirement Income Security Act) plan. [The Supreme Court of Louisiana did not reverse the First Circuit finding

and holding in Cramer, supra that the medical expense plan established by an employer for its employees was a medical expense plan as defined by the Employee Retirement Income Security Act (ERISA). Cramer V. Association Life Insurance Company, 569 So.2d 533 (La. 1990), cert. denied, 499 U.S. 938 (1991).]

The decision of the Court of Appeal, Fifth Circuit, State of Louisiana, also conflicts with decisions of the United States Court of Appeal, Fifth Circuit, in the cases of Memorial Hospital Sys. v. Northbrook Life Ins. Co., 904 F2d 236 (5th Cir. 1990) and Rodriguez v. Pacificare of Texas, Inc., 980 F2d 1014 (5th Cir. 1993). It is submitted that writs should be granted to secure uniformity of jurisprudence.

This conflict between the Court of Appeal, Fifth Circuit, of this state in this matter and the Court of Appeal, First Circuit, and Court of Appeal, Third Circuit, in the Cramer case, supra and West case, supra will cause great confusion and lack of uniformity as to whether a medical expense plan established by an employer for its employees is an ERISA plan. Furthermore, the conflict between the Court of Appeal, Fifth Circuit, State of Louisiana, and the United States Court of Appeal, Fifth Circuit will cause even greater confusion and lack of uniformity. Medical expense plans established by employers for their employees with the same set of facts as this case, the Kornman case, litigated in the federal courts will be held to be ERISA medical expense plans. Whereas, medical expense plans established by employers for their employees with the same facts as in this case, the Kornman case, litigated in Louisiana courts will be held not to be ERISA medical expense plans. Employers, as well as employees in this State will not know whether they have or are participants in ERISA medical expense plans.

It is counsel's understanding that the United States De-

partment of Labor will not join in a writ application to any court unless asked to do so by the court in question. However, it is counsel's further understanding that the position of the United States Department of Labor on the issue of whether ERISA would apply in a fact situation as found in this case, the Kornman case, would be opposite to the holding and decision of the State of Louisiana, Court of Appeal for the Fifth Circuit, i.e., the United States Department of Labor would take the position that the Coast MEP was an ERISA plan.

II. THE MEDICAL EXPENSE PLAN ESTABLISHED BY COAST IS AN INDISPENSABLE PARTY, PLAINTIFFS' LAWSUIT IS PREMATURE, AND PLAINTIFFS' STATE LAW CLAIMS ARE PREEMPTED

A. Indispensable Party

The trial court and the Court of Appeal, Fifth Circuit, erred in not addressing or considering and holding that the ERISA medical expense plan established by Coast for its employees ("Coast MEP") is an indispensable party. The civil enforcement provisions of ERISA are contained in 29 U.S.C. §1132. Section 1132(d) makes clear that an ERISA plan "may sue or be sued . . . as an entity." The statute goes on to state: "Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability is established in his individual capacity under this subchapter." 29 U.S.C. §1132(d)(2). Where plaintiffs are seeking to recover benefits allegedly due to them under the terms of an ERISA plan, the proper defendant is the plan, which may be sued as an independent entity pursuant to 29 U.S.C. §1132(d)(1). Jourdan v. Claims, Inc., 1992 U.S. Dist. LEXIS 2157 (W.D. Mich. 1992); Jenkinson v. Chevron Corp., 634

F.Supp. 375, 377 (N.D. Cal. 1986). Therefore, the ERISA plan established by Coast (the "Coast MEP") is an indispensable party to the suit filed by plaintiffs, and thus, this matter should be dismissed for plaintiffs failure to join the ERISA plan established by Coast ("Coast MEP") as a proper party defendant.

B. Plaintiffs' Lawsuit is Premature

The trial court and the Court of Appeal, Fifth Circuit, erred in not addressing or considering and holding that the plaintiffs' lawsuit was prematurely filed.

Pursuant to the terms of the ERISA plan established by Coast ("Coast MEP"), as set forth in the plan summary, if the plaintiffs believe that their claim was improperly denied, they should have filed an appeal with the ERISA review department of Blue Cross within sixty days after the plan mailed a written notice of denial of the claim. This procedure is fully set forth in the Plan Summary for 1984, Plaintiffs Exhibit "3" in the record, p. 15, Employee Booklet; Plan Summary for 1985, Plaintiffs Exhibit "4" in the record, p. 26, Employee Booklet; Plan Summary for 1987, Plaintiffs Exhibit "6" in the record, p. 15, Employee Booklet. See Appendix Exhibit E. The plaintiffs never filed such an appeal. Their suit is, therefore, premature and should be dismissed since the plaintiffs failed to exhaust their administrative remedies under the ERISA plan.

The U.S. Fifth Circuit Court of Appeals has recently reaffirmed its holding that a failure to exhaust the administrative remedies provided for in an ERISA plan forecloses judicial review of the claim denial. Rodriguez, 980 F.2d at 1016 n.1. See also, Denton v. First Nat'l Bank, 765 F.2d 1295, 1300-03 (5th Cir. 1985); Taylor v. South Central Bell, 422 So.2d 528, 29 (La. App. 5th Cir. 1982), citing, Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980); Steeg v. Lawyer's Title Insurance Corp., 329 So.2d

719 (La. 1976) ("It is well established that the failure to pursue and exhaust administrative remedies precludes judicial relief.") As one court has noted, administrative responsibility rests with those whose experience is daily continual, and not with judges whose exposure is episodic and occasional. Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985).

In this case, the plaintiffs failed to exhaust their administrative remedies before filing suit in state court. Such a failure to exhaust administrative remedies provided for in the ERISA plan forecloses judicial review of the claim denial. Rodriguez, 980 F.2d at 1016 n.1. As stated by the U.S. Fifth Circuit, Court of Appeal, in enacting ERISA, Congress clearly wanted potential plaintiffs to first exhaust their administrative remedies before resorting to the courts. Denton, 765 F.2d 1303.

C. Plaintiffs' State Law Claims are Preempted

The trial court and the Court of Appeal, Fifth Circuit, erred in not addressing or considering and holding that the plaintiffs' state law claims were preempted by ERISA. Plaintiffs' sole basis for recovery is alleged violations of state law and certain Louisiana Revised Statutes. Plaintiffs also contend that they are entitled to penalties and attorneys fees pursuant to La.R.S. 22:657. This statute is completely preempted by ERISA's civil enforcement provision, 29 U.S.C. §1132. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d, 39, 51 (1987). In Pilot Life, the Supreme Court held that the civil enforcement provisions of ERISA were intended by Congress to be the "exclusive vehicle for action by ERISA-plan participants and beneficiaries asserting improper processing of claims for benefits, and that the varying state causes of action for claims within the scope of [section] 1132 would pose an obstacle to the purposes and objectives of Congress." Pilot Life, 95 L.Ed.2d at 50-51. The Supreme Court quoted Massachusetts Life Ins. Co.

v. Russell, 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985).

La.R.S. 22:657 clearly provides a remedy to participants and beneficiaries claiming benefits which was not intended nor provided by 29 U.S.C. §1132. ERISA contains no provision for punitive damages. Russell, 473 U.S. at 144. Therefore, both Louisiana state courts and federal courts have been uniform in holding that ERISA preempts La.R.S. 22:657. Cramer v. Association Life Ins. Co., 569 So.2d 533 (La. 1990), cert. den'd, 499 U.S. 938 (1991). See also, Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 109-110 (5th Cir. 1993); West v. Connecticut General Life Ins. Co., 591 So.2d 1296 (La. App. 3d Cir. 1991); Taylor v. Biue Cross/Blue Shield of New York, 684 F. Supp. 1352, 1356-59 (E.D. La. 1988). Moreover, preemption applies not only to self-funded ERISA plans, but to insured plans as well. The United States Supreme Court specifically held in Pilot Life, supra that ERISA's preemption provisions apply in the context of an insured employee benefit plan. Pilot Life, 95 L.Ed.2d at 45 and 51-52. See also, Cramer, 569 So.2d at 533 (Louisiana Supreme Court likewise applied ERISA's preemption provisions to an insured plan).

The trial court and the Court of Appeal, Fifth Circuit, were in error in holding that ERISA would only preempt La.R.S. 22:657 and would not affect the other insurance laws relied upon by plaintiffs. Other statutes relied upon by the plaintiffs in this case are also preempted. Using the preemption analysis, courts have found that ERISA preempts La.R.S. 22:619(B), another statute relied upon by the plaintiffs. Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105 (5th Cir. 1993). It is submitted that La.R.S. 22:215A(1)(a) is preempted by ERISA. Additionally, the Fifth Circuit noted that other courts have held that the case law holding that ambiguous terms in an insurance contract are to be construed against the insurer is also preempted by ERISA. Tingle, 996 F.2d

at 110 n.25, citing, McMahan v. New England Mut. Life Ins. Co., 888 F.2d 426, 428-30 (6th 1989). The court applied the three part test and found that the law did not spread policy holder's risk but, instead forces the insurer to bear the legal risk associated with the ambiguous policy language. Id. Additionally, the court noted that the law was not aimed directly at the insurance industry because it derived from state law. Id. See also, Brewer v. Lincoln National Life Ins. Co., 921 F.2d 150 (8th Cir. 1990), cert. den'd, U.S. _, 111 S.Ct. 2872, 115 L.Ed.2d 1038 (1991) (Missouri law requiring that ambiguities in insurance contracts be construed against insurer is preempted by ERISA).

* * *

CONCLUSION

The Judgment of the Court of Appeal, Fifth Circuit, affirming the Judgment of the 24th Judicial District Court is in error for the many reasons set forth in this Application for Writ of Certiorari, Remedial Writ or Writ of Review.

The Judgment conflicts with decisions and judgments of other courts of appeal of this state and with the United States Court of Appeal for the Fifth Circuit as to what medical expense plans provided by employers for their employees are ERISA plans. Further, there are significant issues of law and interpretations of Louisiana statutes that should be resolved by this Court. In addition, the Judgment of the Court of Appeal, Fifth Circuit, for the reasons set forth in this application, has interpreted statutes, both federal (the Employee Retirement Income Security Act) and State of Louisiana statutes erroneously. Said erroneous interpretations will adversely effect efficient judicial administration, fundamental fairness to litigants, cause serious financial and other devastating consequences, affect the public interest

and also cause material injustice.

Therefore, the applicant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana) prays that this application be deemed sufficient, and that this Court grant its requests for a writ of certiorari, remedial writ or writ of review from the Judgment of the Court of Appeal, Fifth Circuit.

Respectfully submitted,

s/Sylvan J. Steinberg
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VERIFICATION

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, the undersigned authority, personally came and appeared:

SYLVAN J. STEINBERG

who being first duly sworn, did depose and say:

That this Verification is made pursuant to Rule 10, Section 2(d) of the Rules of the Louisiana Supreme Court;

That he is counsel of record for Applicant, Louisiana Health Service and Indemnity Company (Blue Cross/Blue Shield of Louisiana),

That he has read the foregoing Application for Writ of Certiorari, Remedial Writ or Writ of Review of Judgment;

That all of the allegations contained therein are true and correct to the best of his knowledge, information and belief;

That a copy of the Application for Writ of Certiorari, Remedial Writ or Writ of Review of Judgment has this day been filed with the Clerk of Court of the Court of Appeal, Fifth Circuit, and delivered to the Honorable Clarence E. McManus, and to all other counsel of record at the addresses listed below by depositing same in the United States Mail, properly addressed and postage prepaid.

s/Sylvan J. Steinberg
SYLVAN J. STEINBERG

SWORN TO AND SUBSCRIBED
BEFORE ME ON THIS 15th
DAY OF DECEMBER, 1995

s/Fred Bronfin
NOTARY PUBLIC

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